

Understanding Reproductive
Health - A Resource pack

08019

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**UNDERSTANDING
REPRODUCTIVE HEALTH**

A Resource Pack

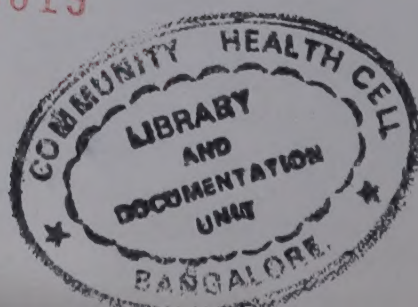
**Booklet – One
INTRODUCTORY BOOKLET**

SAHAYOG



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FOREWORD

(to request Poonam)

ACKNOWLEDGEMENTS

This Resource Pack was conceived as a kind of ready reckoner for those who wish to learn about the different facets of Reproductive Health and as such it was estimated that it would be a simple task to produce. Instead it has taken over a year to produce and has needed inputs from over twenty people from different parts of the country. Managing correspondence and contributions from so many different sources was a difficult process, particularly so, because the editors were based in a remote area. This is where the great communication revolution was indeed a great boon. Over the one year in which we were involved in producing this Pack we graduated from a tenuous email link via Delhi to a full fledged local internet connection, which has given new meaning to the concept of being connected.

When we ventured out to prepare the Resource Pack all we had was an idea and lots of enthusiasm, and no experience in preparing anything remotely similar. A few steps into the actual preparation we realised how difficult the task would be. Firstly, having been involved in some aspects of Reproductive health at an operational level we had started out with confidence that we had an idea of the ground that the idea of Reproductive health covered. Working on the different aspects with which we were a little less familiar, made us realise how little we knew. This is where other friends and colleagues helped. We received unstinting support from all whom we asked. Without their support this Resource Pack would not have seen the light of day. We would specially like to thank Saroj Pachauri, Sagri Singh, Saraswathy Raju of the Population Council for providing advice as well as agreeing to pitch in with contributions and for reviewing. All our co-fellows of the MacArthur Foundation who agreed to go along with this idea and seeing it through, deserve all our gratitude for readily responding to our continuous requests. Thank you Aleyamma, Anuja, Bela, Dhanu, Geeta, Gopi, Kirtana, Kirti, Rahul, Ranjan, Siddhi, Shubhadra, Vasavi, and Vikram for providing all the support despite your own busy schedules. Alok, Alka and Amitrajit deserve our gratitude for allowing us to rope them into this project. We would also like to thank members of the SAHAYOG staff for making allowances for the two of us, and for providing all the support that we required. And a big thank you to Diya for putting up with our long absences and to Ma for holding the fort.

This Resource Pack would have remained an idea but for the tremendous support and encouragement that we received from Poonam Muttreja. Poonam not only expedited the financial aspect but also rooted for the idea all through. We would also like to thank the MacArthur Foundation for providing the financial support necessary for producing this Resource Pack.

Jashodhara Dasgupta
Abhijit Das

INTRODUCTION

How the idea of this Resource Pack was born

Reproductive Health is one of the new ideas that has caught our country by storm. Population has long been a bugbear for politicians, planners and pundits in India. Over the last year or so the term reproductive health is also being cautiously mentioned in relation with population. The Government has re-christened its family planning programme and the World Bank has given it a very large loan in the name of reproductive health. NGOs all over the country are preparing proposals for becoming Mother NGOs or for different projects related to reproductive health. For many reproductive health is a new name for Family Planning, for others it is a reincarnation of Mother and Child Health (MCH).

For the last five years the John D and Catherine T MacArthur Foundation has been awarding a number of fellowships to Indians from different backgrounds to work on the issue of Population Innovations. Much of these innovations have had to do with reproductive health and a quick glance at the profile of fellows over these five years gives an idea how people from diverse backgrounds are getting interested in reproductive health. Fellows have included activists, grassroots workers, doctors, media persons, theatre persons, film makers, researchers, trainers, psychologists, psychiatrists and so on. This is perhaps a reflection of the different kinds of people who are getting interested in the subject.

The idea of this Resource Pack was born at one of the annual get togethers of the different individuals who had been awarded this fellowship. Many of the fellows felt that they had learnt a lot about the complexity of Reproductive Health during the period of their fellowship. Newer fellows were confused with the same complexities. An idea was then mooted that a kind of Resource Pack be prepared by the people who felt that they had learnt something about subject. Since most of the fellows were involved in work which was directly concerned with the subject – it was felt that this resource pack would be grounded in reality and not just deal with concepts. Two of us took the challenge of coordinating the effort while the others promised to chip in. It has taken a little over a year to put this pack together, and in putting this together we learnt how far more complex the subject is than what we had originally thought. Reproductive health is a vast subject as the reader of this pack will soon realise; with various perspectives, different specialities, contentious policies and complex operational details. This resource pack tries to provide just a glimpse of all this. It is not a definitive work, nor a theoretical masterpiece. It has been put together primarily by practitioners and thus may lack the technical finesse that academics might insist upon. It also lacks dispassionate objectivity which is often the hallmark of a good text-book. Instead it is loaded with the writers own perspectives which is born out of struggling with the different issues in the workplace. This resource pack is clearly written keeping the interests of women, especially marginalised women in mind.

Objectives of the Resource Pack

This resource pack is primarily meant for all those who may be interested in the subject of Reproductive Health. As has been mentioned earlier, today a large number of individuals are getting interested in the subject. Any way the concept itself is very new and despite the name is not exclusively a 'health' subject. In its complexities it involves social sciences, medical sciences, women's issues, rights, population sciences and demography and so on. Thus it could be a matter of interest to any one in any of these specialities. Also reproductive health is a matter of great interest to NGO workers because of their inherent interest in the health of women but also because of the potential of diverse funding opportunities that exist today in the name of reproductive health. We also hope that the many bureaucrats and the doctors who are involved in designing and implementing reproductive health interventions for the millions in our country can take some time out to go through its pages. Thus the resource pack could be of interest to a wide range of people with different interests and specialities.

This resource pack has been deliberately designed in booklets so that the interested reader may straight away refer to the issue of her/his interest. We would like to warn readers that if you choose to look up the subject in which you have experience and expertise, you will find it very basic, because the entire resource pack has been kept simple for the first time user. This resource pack is in many ways a primer, and not a reference book. It is assumed that the resource pack will primarily be used for those who wish to work on the subject and thus we have included many operational ideas as well as a small resource section which is intended to help the practitioner.

How the Resource Pack was put together

This resource pack is the collective effort of a large number of individuals. As has been mentioned earlier the lead for putting this Resource Pack together was taken up by a few individuals who had been awarded a fellowship in Population Innovations by the MacArthur Foundation. The task of editing was taken up two of them while others took upon the task of sending in their contributions. The first draft of the different booklets took a considerable time to put together because the fellows live all through the length and breadth of the country. While some have access to email or courier, others who are working with communities in remote areas often do not get mail regularly. Once the first rough draft was ready, it was sent to for review to other practitioners in the same speciality as the subject matter of the booklet. Some of the reviewers were fellows, while others were respected practitioners in the discipline. We tried to get each booklet reviewed by two independent reviewers, but this was not always possible. Finally when the reviewers had send in their comments their comments and suggestions were incorporated into the booklet. Finally the entire Resource Pack was reviewed by --- independent reviewers. All reviewers and contributors are essentially practitioners as has been mentioned earlier. A detailed list of contributors and reviewers is provided at the end of the Introductory Booklet.

Structure of the Resource Pack

The Resource Pack comprises of twelve booklets including the Introductory booklet. Each of these booklet deals with one theme related to Reproductive Health. Thus eleven themes are covered in the pack. These different themes are:

Booklet Number	Theme
Two	RH Policy and Advocacy :Changing Paradigms
Three	Reproductive and Sexual Rights : Exploring new frontiers
Four	Population and Demography : Understanding Numbers
Five	Women's Health –1: Maternal health is still important
Six	Women's Health –2: The Promise of better health
Seven	Contraception : Going beyond Family Planning
Eight	Adolescents : The Emerging Agenda
Nine	Men's Health and Responsibility: Forging new partnerships
Ten	HIV/AIDS & STD : Coming to terms with reality
Eleven	Sex and Sexuality : Acknowledging ourselves
Twelve	Women have Minds Too! Exploring the interface between RH and Mental health

Contents of the different Booklets- Each of these eleven booklets is basically divided into four sections. The first section deals with ideas, concepts and definitions which are associated with the subject of the booklet. The second section deals with perspectives and includes discussions and debates around the subject, especially with regard to India. The third section deals with operational aspects and includes both tips and guidelines for working on the issue as well as brief introductions to some organisations which are currently involved in working on it. We have tried to include three or four organisations in each booklet, and this has meant that we have had to choose some and the choice has always been difficult, with many excellent organisations pioneering work in many of these relatively new and unexplored fields. The final section is ambitiously referred to as the Resource section and has a select bibliography (primarily of books which we found useful in preparing this Resource Pack). This reading list is not exhaustive. There are also names of Journals, or documentation centres or training centres or resource organisations wherever relevant.

This Introductory booklet is also a kind of summary for the whole pack and includes a list of organisations involved in different aspects related to Reproductive Health. It also includes an index of the different topics that have been discussed in the different booklets.

INTRODUCTION TO REPRODUCTIVE HEALTH

What is Reproductive Health

The idea of reproductive health has emerged from a discourse between the twin ideas of family planning/population control and women's health needs. It was developed through a process of dialogue and critique between the population control/family planning oriented planners on one side and the women's health activists on the other. It was also the result of the clear failure of population control/family planning policies and programmes to deliver the promised results and in improving the quality of women's lives. The International Conference of Population and Development (ICPD) at Cairo in 1994 formalised the acceptance of Reproductive Health as an imperative for the states of the world. A very comprehensive definition of Reproductive Health was developed at the ICPD and runs as follows-

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore, implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods. Techniques and services that contribute to reproductive health and well-being through preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related in reproduction and sexually transmitted diseases. (UN 1994)

Drawing from this it means that reproductive health includes:

- the ability to have a satisfying and safe sex life
- the freedom to decide if, when and how often to reproduce
- the right to be informed and have access to safe, effective and affordable methods of family planning and methods for fertility regulation
- the right to have access to appropriate health care services

Another aspect which is stressed in this definition is that reproductive health has to be considered together with reproductive rights. These rights include the right of individuals and couples to decide freely and responsibly about the number and spacing of children, the means to do so, the right to make reproductive decisions and in short the right to attain the highest level of sexual and reproductive health. The definition goes on to emphasise that mutually respectful and equitable gender relations are essential for the promotion of

these rights.

Some of the issues covered under reproductive health include:

Safe motherhood, Unsafe abortion, Women's health, Child survival and health, Family planning and contraception, HIV and AIDS, infertility, reproductive tract infection, cancers of the reproductive tract and so on.

What are the factors affecting reproductive health

Reproductive health is thus not just a simple matter of ensuring adequate family planning education and services, nor is it just a matter of providing appropriate health care services. Reproductive health includes the recognition of the different factors which stand in the way of individuals achieving their reproductive health potential. These factors are briefly touched upon in the ICPD definition as '*reproductive health eludes many of the world's people because of such factors as: inadequate levels of knowledge about human sexuality and prevalence of high-risk sexual behaviour; discriminatory social practices; negative attitudes towards women and girls; and the limited powers many girls have over their sexual and reproductive lives*'. Thus reproductive health is affected by a large number of factors like:

- level of knowledge about the body and its functions
- social discriminations, especially discriminations towards women and girls
- gender and power relations in society
- access to and quality of health care services
- access to information and services about health care and contraception

In order to secure reproductive health and rights for all individuals it is necessary to take action on social and economic fronts like – poverty, empowerment of women, gender equality and equity, education, situation of children sustainable development interventions as well as in health related areas.

Whose reproductive health is of concern

In the times before reproductive health was acceptable as an idea, Family Planning (FP) and Maternal and Child Health (MCH) programmes focussed exclusively on women and at the most on couples where the woman was in the reproductive age group. This led to the total neglect of other women. Reproductive health has a much broader framework and includes children, adolescents as well as older women. Reproductive health is equally concerned with men's health, and is also interested in men as essential partners and supporters of women's health. The reproductive health and rights of neglected populations like indigenous people, migrants and refugees as well as persons with disabilities has also to be taken into account.

What are the appropriate health-care services included within reproductive health

The range of services include the whole range of preventive, promotive and curative

curative services which includes information, education and communication (IEC), counselling as well as curative services. The different conditions for which such services must be made available include – ante-natal, delivery and post-natal period, infertility, abortion, reproductive tract infections, STDs and HIV/AIDS, Family planning, cancers of the reproductive tract and so on.

Reproductive Health in India

India was one of the signatories of the Programme of Action emerging out of the ICPD, and as such was committed to changing its programmes and policies in lines with its recommendations. The Government engaged in a review of its existing Family Planning programme with the assistance of the World Bank and developed a new Reproductive and Child Health approach. In April 1996, the Government formally withdrew centrally determined method specific contraceptive targets. In October 1997 the Reproductive and Child Health (RCH) programme was formally launched. Today the Government has in place a Community Needs Assessment (CNA) approach for determining communities' needs and implements a RCH programme.

In the non governmental sector there are a large number of individuals and organisations involved in different kinds of activities and experiments in reproductive health. These activities had started long before the Cairo conference and many Indian women's health practitioners and activists have been at the forefront of negotiating the changes that led to the acceptance of a reproductive health agenda.

ORGANISATIONS INVOLVED IN WORKING ON REPRODUCTIVE HEALTH

While Reproductive Health is a relatively new idea in India, there are a large number of excellent organisation, primarily in the Non-Governmental sector who have been involved in pioneering work. Many of these organisations have been engaged in creating new understanding and defining new boundaries, in many of the hitherto unexplored and little understood aspects of human behaviour which come under Reproductive health. Others have been evolving new paradigms of providing services for conditions which have long been neglected or even unknown. Some of the contributors have been involved in these pioneering efforts while others have drawn inspiration from them. While a small number of organisations have been referred to in each booklet, this section will primarily deal with organisations which work in cross-cutting areas like Training, Research, Resource Support and so on. These organisation are being referred to here for their generic expertise, while specialised expertise finds mention in the relevant booklets. The editors have tried to include organisations from all around the country , but they are aware that some regions may be under represented.

Research organisations- Some of the organisations involved in field based behavioral and operations research are mentioned below. Many of these organisations also provide trainings in conducting research. The Ford Foundation has recently commissioned an extensive review of literature of Reproductive and Sexual Health and this review is being coordinated by Sundari Ravindran of RUWSEC. There are five teams working on five topics which are Abortion, Women's Health, HIV and women, Sexuality and Health Systems Research. It is expected that an extensive literature review will soon be available as a result of work of this team.

Centre for Enquiry into Health And Themes (CEHAT) This group is involved in research and documentation of rational health systems, and also runs a documentation centre of Reproductive Health	2nd Floor, BMC Building, 135 Military Road, Bamandayapada, Marol, Andhri East Mumbai- 400059 Phone : 91-22-851 9420, Fax : 850 5255, Email- cehat@vsnl.com
Centre for Operations Research and Training (CORT), Conducts operations research as well as training programmes in qualitative research.	405, Woodland Apartment, Race Course, Vadodra – 390007 Tel – 0265-326453, 326034, 336875
Christian Medical College, Vellore The Community Health and Development Department (CHAD) runs one of the best training courses in epidemiology and biostatistics, as well as conducts research from a community health angle.	Department of Community Health and Development (CHAD), Christian Medical College, Bagayam, Vellore, Dist. N Arcott, Tamil Nadu
Foundation for Research in Health Systems	6, Gurukripa, Apartments, 183, Azad Society,

This organisation is involved in conducting research in Health systems as well as conduct trainings in quantitative methods	Ahmedabad, 380015 Email -frhsad@ad01.vsnl.net.in
KEM Hospital Research Centre This Centre is active in conducting different kinds of clinical as well as social research in Reproductive Health	Sardar Mudaliar Road, Rasta Peth, Pune 411001, India Tel-0212-625600 Email-kem.pune@sm4sprintrpg.sprint.com
Operations Research Group As the name implies this organisation is involved in operations research. It also conducts on qualitative research on Reproductive Health	Rameshwar Estate, Subhanpura, Vadodra, Gujarat, Ph-0265-381461/76
Population Council Population Council is involved in supporting and conducting different kinds of research on the issues related to Reproductive Health. They also have a number of very useful publications which include reports, papers as well as books.	Zone 5A, Ground Floor, India Habitat Centre, Lodi Road, New Delhi -110003. Ph-011-4642901/02
SYNTHESIS : This group is involved in providing training support for organisations interested in upgrading their research skills.	B-322, Clover Gardens, 4 Naylor Road, Bund Gardens, Pune-411001, India, Telefax- 020-627716, Email- sidbela@vsnl.com

Training in different kinds of research is available in many schools of Public Health in many universities outside the country. Most of these are in the form of short summer course and run during the summer. Some of the schools which may be contacted for such course include the London School of Health and Tropical Medicine, School of Public Health , Johns Hopkins University, School of Public Health, Harvard University. Information about these courses is also available on the websites of universities.

Organisations providing training and other kinds of resource support– There are a number of organisations which are involved in providing training in reproductive health to health care functionaries in the NGO sector. Training for Government functionaries are primarily conducted by the National Institute of Health and Family Welfare (NIHFW), and the different State Institutes. For the practitioner in the field one of the most immediate needs is also the availability of different kinds of resource material. These could be in the nature of extension material like flashcards and booklets, simple books in the regional languages for health workers, training kits and manuals or simply a documentation centre where essential information is easily available. Some of the organisations which are in a position to provide this kind of support are mentioned below:

<p>Catholic Health Association of India (CHAI) This network of Catholic organisations working for health provides a variety of training programmes in health. They also publish a monthly journal called Health Action. One important training is concerned with the use of herbal medicines in primary health care.</p>	<p>P B No. 2126, 157/6, Staff Road, Gunrock Enclave, Secunderabad – 500003, Andhra Pradesh. Ph-040-7848293,7848457,7841610, Email- chai@hd1.vsnl.net.in</p>
<p>Centre for Health Education Training and Nutrition Awareness (CHETNA) CHETNA runs a training and resource centre for women's health and provides different kinds of trainings, as well as produces excellent material on the subject. CHETNA primarily works with organisations in Gujarat and Rajasthan</p>	<p>Lilavatiben Lalbhai's Bungalow Civil Camp Road, Shahibaug, Ahmedabad 380004, Gujrat Phone : (079) 786 8856, 786 5636 Email: chetna@adinet.ernet.in</p>
<p>CINI- Chetana This training centre is affiliated with the community based health project of CINI, and is involved in providing training in RH in West Bengal and other states in the east.</p>	<p>Village – Daulatpur, P.O. Pailan via Joka, Dist. 24 Paraganas South, West Bengal. 743512 Ph –033-467 8192,467 1206 Email- cini@cal2.vsnl.net.in</p>
<p>Indian Institute for Health Management and Research (IIHMR) This organisation provides training for managers of Reproductive Health programmes. It is affiliated to the University of North Carolina for a MPH programme.</p>	<p>1, Prabhu Dayal Marg, Sanganer Airport Jaipur Phone : 0141-550770,551685 Email - root@iihmrj.sirnetd.ernet.in</p>
<p>Institute of Health Management Pachod (IHMP) This institute is involved in providing training to health personnel of different categories, especially from the middle and senior management. Many of the trainings are not specific to Reproductive Health</p>	<p>Pachod District – Aurangabad-431121 Maharashtra Phone : 02431-21419,21382 Email : ihmp@giaspn01.vsnl.net.in</p>
<p>Jamkhed Institute of Training and Research in Community Based Health and Population This is affiliated to one of the pioneering institutions for community health in the country, if not the world. It is involved in conducting different kinds of training programmes. Trainings related to RH</p>	<p>Comprehensive Rural Health Project, Jamkhed, Dist- Ahmednagar, Maharashtra –413201. Phone (02421) 21322, 21323 Fax- (02421) 21034</p>

include MCH related trainings.	
PRERNA Population Resource Centre This Centre is affiliated to CEDPA and is primarily involved in providing RH related training to the projects supported by the USAID sponsored SIFPSA programme.	19, Laxman Puri, Faizabad Road Lucknow-226016, Uttar Pradesh Phone : 386715, 387884 Fax : 387884
SAHAYOG SAHAYOG is involved in conducting field based studies as well as providing training and producing material in Hindi on the issue of women's health. SAHAYOG primarily works with NGOs in Uttar Pradesh and in Bihar.	Premkuti, Pokharkhali, Almora- 263601, Uttar Pradesh Phone & Fax : (05962) 32919, 33029 Email : sahayog@vsnl.com
Voluntary Health Association of India and state VHAs. While VHAI is involved in conducting trainings in the management of community health programmes its state units provide specific trainings in the local language. Popular training provided by state VHAs is the training of TBAs, and training i	40, Institution Area South of I.I.T Behind Kutab hotel New Delhi-110016 Phone : 6518071-726962953 Fax : 011-6853708 Email : VHAI@del2.vsnl.net.in

UNFPA brings out a Directory of Training Courses in Reproductive Health which catalogues course from aroound the world. This directory may be obtained either from their country office or from their headquarters

Delhi Office	Headquarters
55, Lodi Estate, New Delhi 110003, India	220 East 42 nd Street, New York N.Y. 10017, USA

There are a number of organisations which run documentation centres. Some of these organisations are mentioned below:

AKSHARA, Neelambari 5th Floor Road 86 Opposite Portugese Church H. Gokhale Road Dadar (W), Bombay 400 028 Phone 022-4309676 Fax 022-4319143 E-mail lakshmi@ilbom.ernet.in	ISST East Court,Upper Ground Floor, Zone 6,India Habitat Centre, Lodhi Road, New Delhi -110003 Ph- 011 464 1083 E-mail- isstdel@giasdl01.vsnl.net.in
JAGORI C – 54, South Extension Part II, New Delhi	SAKHI TC 27/2323, Convent Road,

Tel. 6257015 Email: system@jagori.unv.ernet.in	Trivandrum- 695001. Ph- 0471-462251 Email Sakhi@md2.vsnl.net.in
SANHITA	IWID E2, B Block 4th Floor Parsh paradise Aparts. 109 G.N.Chetty Road Madras- 600 017 Phone 044-8260689 Fax 044-8264728 E-mail- martha@iwid.ilmass.ernet.in
VHAI (see above)	SAHAYOG (see above)
CHETNA (see above)	CEHAT (see above)

Comet Media Foundation This group is involved in material preparation and actively disseminating it .	Topiwala Lane School Lamington Road Mumbai-400 007 Phone 0223869052 Fax-022-3870901 E-mail - admin@comet.ilbom.ernet.in
Drishti Media Group Is involved in highlighting the situation of women and involved in promoting awareness about women's empowerment and reproductive health through film and theatre.	B-1 Divya Aparts. Near Carnival Restaurant, Bokadev Ahmedabad-380 054 Phone 078-674137
Jana Sanskriti This group is involved in promoting women's empowerment and reproductive health using a unique form of theatre.	Sanjay Ganguly, 65 A Kalyani Road, vill. Prasadpur P.O. Hridayapur Dist 24 paraganas N West Bengal Tel: 033 552 1499 Fax- 033 5523162 Email - theatre@cal2.vsnl.net.in
Madhyam Communication Madhaym is invoved in producing material as well as providing communication training on Reproductive Health issues. It publishes a journal called VOICES.	Sucharita Eswar, Post Box 4610, 59 Miller Road Benson Town Bangalore-560046 Phone : 080-5546564
Magic Lantern Foundation This organisation is involved making short films as well as publishing a newsletter on development related media issues	Gargi Sen and Ranjan De, J-1881, Chittaranjan Park New Delhi-110019 Phone : 011-6221405 Email : magicLF@giadl02.vsnl.in
UNNATI Features Unnati features is involved in producing features related to health and development, particularly reproductive health and placing them in both National dailies as well as regional Hindi language dailies	S-20 Greater Kailash II, New Delhi 110048, Tel -011 623 7509;647 4144 Fax-011 647 4144 Email unnati@nde.vsnl.net.in
Women's Feature Service This feature service is involved in promoting articles related to women in both the press and electronic media.	Anita Anand, Director, 1 Nizamuddin East New Delhi -110 013 Phone 011 462886, 4632546 E-mail- wfs@unv.ernet.in
Media Advocacy Centre (New Name) This centre is involved in media research and advocacy and reproductive health is one of its core areas.	Akhila Sivadas, R-1, Press Enclave, Saket, New Delhi Tel-011-686 5921;623 1360

Implementing organisations - There are a large number of organisations involved in implementing different kinds of programmes within the Reproductive Health framework. A list of three of four organisations, according to the kind of work they are involved in has been provided in each of the booklets. The interested reader will find an exhaustive list of organisations working on the issue in two excellent directories. Details of these directories is as follows:

1. Reproductive Health Database- Compiled by Department for International Development(DFID), December 1998.

This Data base includes thematic collection of organisations with a brief description of their work in the particular theme as well as a matrix at the end which provides the range of activities each organisation described in the database is involved in. The database includes research, training as well implementation organisations. Contact information of each organisation , including names of contact persons and phone and fax number and email are also provided. A copy of this book may be obtained from the office of DFID.

2. Community based programmes addressing Women's Reproductive Health Needs in India, - Compiled and edited by Masuma Mamdani , 1998.

This document includes details of the work of 72 organisations which have community based programmes for womens health. The organisations are arranged alphabetically and the documentation is very detailed as it has been substantiated by field visits. Contact information of each organisation , including names of contact persons and phone and fax number and email are also provided. A copy of this book may be obtained from the office of the Ford Foundation.

Besides these two booklets the Voluntary Health Association of India brings out periodic documentation of different organisations involved in community Healath related activities in a series called the ANUBHAV series. Organisations involved in working of women's health are also coveren in this series. A list of all the organisation covered may be obtained from the office of VHAI.

Networks of organisations- There are a few networks of organisations working on the issue of women's health or reproductive health. There are some more which are more broad based. Some of these networks are:

<p>Women and Health Network (WAH!) This is a network of voluntary organisations and activists on the issue of Women's Health. Important activities of the network have been conducting trainings and in advocacy for a women's health policy</p>	<p>WAH! Secretariat CHETNA Lilavatiben Lalbhai's Bungalow Civil Camp Road, Shahibaug, Ahmedabad 380004, Gujrat Phone : (079) 786 8856, 786 5636</p>
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	Email: chetna@adinet.ernet.in
HEALTHWATCH This network of NGOs, academics, activists and researchers is primarily focussed on implementation of the ICPD agenda in India.	A-5 Institute of Economic Growth University Enclave Delhi -110007 Phone : 7256134 Email : visaria@sidev.Delhi.nic.in
Healthwatch, U.P.-Bihar This network of NGOs and activists and organisations in the two north Indian states is involved in advocacy for promoting a gender and reproductive health based programmes .	2015, C Block, First Floor, Indira Nagar, Lucknow -226016 Email- sahayog@vsnl.com
Forum for Women's Health This is a campaign group working on women's health. They have been involved in the campaign against hazardous contraception and against coercive population control	C/o Swatija Manorama, 9, Sarvesh, Govind Nagar, Thane (East), Maharashtra- 400603, Ph- 542 3532
Shodhini Network The Shodhini Network was involved in a large multicentre study on the efficacy of herbal medicines in treating women's illnesses.	C/o N.B. Sarojini J-1881. Chittaranjan Park New Delhi-110019 Phone : 011-6221405 Fax : 011-6223894/6231801
Voluntary Health Association of India (VHAI) VHAI is a federation of state level networks of NGOs involved in health.	40, Institution Area Behind Kutab Hotel New Delhi-110016 Phone :011-6518071 Fax : 011-6853708 Email : vhai@del2.vsnl.net.in
Medico Friends Circle (MFC) The MFC is a loose network of Health Activists , doctors and researchers,who meet once a year. They also produce a monthly bulletin.	50, LIC Quarter, University Road, Pune - 411016.

Funding organisations –Much of the innovative work in the non-governmental sphere is kept alive through grants from different funding organisations. Infact organisations like the Ford Foundation and the MacArthur Foundation have made special efforts to support innovative work related to Reproductive Health. The Department of Family Welfare has also emerged as a major source of support for community based projects through its Mother NGO scheme in the Reproductive and Child Health Programme. Some of the funders who support work in Reproductive health and related areas include

The John D and Catherine T MacArthur Foundation – The Foundation supports innovative individuals through its annual Fellowship programme, as well as provides grants to institutions.	Zone 5A, First Floor, India Habitat Centre, Lodhi Road, New Delhi –110003, Ph –011-464 4006, 4007 Email-macarth@giasd101.vsnl.net.in
Ford Foundation – The Foundation has been very active in supporting organisations who have been pioneering work in different spheres of Reproductive Health, both in the spheres of research and in interventions	55 Lodhi Estate, New Delhi , 110003, Tel –011 461 9441.
Mother NGO scheme – This scheme of the Department of Family Welfare is supporting NGOs in different states to become conduits for providing funds and other kinds of support to grassroots NGOs for implementing RCH projects	C/o Joint Secetary, Department of Family Welfare, Ministry of Health and Family Welfare, Nirman Bhawan, New Delhi 110001.
Rockefeller Foundation – Provides grants primarily for research related projects in the sphere of Reproductive Health	1133 Avenue of Americas, New York NY 10036, USA.
World Health Organisation – the WHO provides support to research on Reproductive Health through its special unit called Special Programme of Research, Development and Research Training in Human Reproduction	World Health Organisation, 1211, Geneva 29 Switzerland. Fax- 41-22-791 4171
Programme for Appropriate Technology in Health (PATH) Is involved in supportin research and development, technology transfer and allied activities. Reproductive health is one of their key issues of concern	4, Nickerson Street, Seattle, WA 98109, USA. Ph: 206-285 3500
USAID This is the official development agency of the US government. Population, Health, and Nutrition is one of the key areas of support for USAID. The Innovations in Family Planning Services (IFPS) is involved in a large project in UP. PACT/CCRH and APAC are two other projects concerning Reproductive Health	Qutab Hotel Road, Tara Crescent, New Delhi 011-685 6301.
International Centre for Research on	1717 Massachusetts Avenue, Suite 302

Women (ICRW) Provides technical and financial support for research projects on women's health	Washaington, DC 20036, USA Phone : 202-7970007 Fax : 202-790020
CEDPA While CEDPA is primarily involved in providing technical support it also provides financial support to some NGOS	Liason Office, 42 Shanti niketan, New Delhi 1100 Ph-
Department for International Development (DFID) Originally known as the British ODA, this organisation supports reproductive and sexual health and AIDS related work in India	C/o The British High Commission 50 M Shantipath (Gate 4), Niti Marg, Chanakyapuri, New Delhi 110021, Ph: 011-687 1647, 687 1655
Danish International Development Agency (DANIDA) DANIDA supports social sector activities, which include health and women's development.	Technical Advisor in Development, Royal Danish Embassy, 11 Aurangzeb Road, New Delhi 110001. Ph – 011 301 0900
DSE The DSE has been instrumental in supporting the entire WAH! initiative .	Deutsche Stiftung fur Internationale Entwicklung (DSE) German Foundation For International Development Breite StraBe 11, D -10178 Berlin (Mitte) Germany Phone 49-030-23-11-92-20 Fax 49-030-23-11-92-22, 23-11-91-11

There are many other funding organisations who are willing to support community based reproductive health interventions. For further details the reader can consult the following publication:

Foreign Aid and NGOs

Edited by : Manoranjan Mohanty and Anil K Singh

Published by and available from : VANI, B-52 Shivalik, New Delhi 110017.

BOOKS AND MATERIALS ON REPRODUCTIVE HEALTH

Subject specific reading lists have been provided at the end of each booklet. The following is a list of books we have found useful arranged according to use for general reading on Reproductive Health.

Annotated Bibliographies

1. George, A. et.al. 1994. Women's Reproductive Health and Sexuality an Annotated Bibliography. Bombay : Tata Institute of Social Sciences.
- Baru, R. and R. Hebbar. 1993. Sociological Aspects of Women's health: A Select Bibliography. New Delhi: VHAI.
2. ARROW. 1997. Gender and Women's Health: Annotated Bibliography, No. 2. Kuala Lumpur: ARROW.
3. ARROW. 1996. Women Centred and Gender Sensitive Experiences: Annotated Bibliography. Kuala Lumpur: ARROW.
4. ARROW. 1994. Towards Women Centred reproductive Health: Annotated Bibliography, No. 1. Kuala Lumpur: ARROW.
5. WHO. 1995: Women's Health and Development: An annotated Bibliography: Geneva, WHO

Books

1. Pachauri Saroj 1995: Defining a Reproductive Health Package for India: A proposed framework, Population Council, New Delhi
2. Das Gupta Monica, Chen Lincoln, Krishnan T.N. 1998: Women's Health in India: Risks and Vulnerabilities: OUP, Delhi
3. Lingam Lakshmi 199 : Understanding Women's Health Issues: A Reader: Kali for Women, Delhi
4. Pachauri Saroj 1999: Implementing a Reproductive Health Agenda in India: The Beginning: Population Council, New Delhi
5. Burns Augusta, Lovich Ronnie, Maxwell Jane, Shapiro Katherine 1997: Where Women have no Doctor : The Hesperian Foundation, Berkeley
6. United Nations 1994: The Programme of Action of the International Conference on Population and Development: New York
7. Gittelsohn, J.et.al. 1994. Listening to Women Talk About Their Health: Issues and Evidence from India. New Delhi: Ford Foundation.
8. MoHFW. 1997. Reproductive and Child Health Programme Schemes for Implementation. India: Deptt, of Family Welfare

Journal

Reproductive Health Matters – This journal is published biannually and in each of its issues takes up a different theme related to Reproductive Health, which it covers comprehensively. The journal is published from:

Reproductive Health Matters,
29-35, Farringdon Road,
London – EC 1M3JB, England.

Tel (44-171) 2428656

Information Kits

1. Family Care International. 1999. Sexual and Reproductive Health Briefing Cards .Netherlands: Family Care International
2. Germaine A and R.K 1995. The Cairo Consensus : The right agenda at the right time. New York International Women's Health Coalition
3. HERA . Women's Sexual and Reproductive Health and Rights-Action Sheets. New York: HERA
4. Sethi, G. and M. Carter. 1996. The Reproductive Health Approach, - What , why and How. New Delhi: Population Council.
5. UNFPA. 1998. Population Issues Briefing kit 1998. New York; UNFPA

Books on conducting Research in Reproductive and Sexual Health

1. Gittlesohn Joel, Pertti J Peltto, Bentley Margaret E, Bhattacharya Karabi, Russ Joan 1995: Women's Health Network Protocol for Using Ethnographic methods to investigate Women's Health : The Johns Hopkins University, Ford Foundation.
2. Roberts Helen 1990: Women's Health Counts: Routledge, London
3. Roberts Helen 1992: Women's Health Matters: Routledge, London
4. Graham Wendy, MacFarlane Sarah 1996: Guidelines for selecting Reproductive Health Indicators: WHO, Geneva
5. Miller Robert et al 1997: The situational Analysis Approach to Assessing Family Planning and Reproductive Health Services: A Handbook: Population Council, New York
6. Graham Wendy et al 1995 : Asking Questions about Women's Reproductive Health in Community Based Surveys: Guidelines on scope and content : London School of Hygiene and Tropical Medicine, London

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**Understanding
Reproductive Health**

A Resource Pack

Booklet – Two

REPRODUCTIVE HEALTH POLICY AND ADVOCACY

Changing Paradigms

SAHAYOG

Engaging and Confronting

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VHAI - New Delhi	Tong Swasthya Bhawan, 40 Institutional Area, South of IIT NewDelhi-110 016 Phone 0116618071,6965871,6962953 Fax 0116853708

Addresses of organisations involved in Reproductive Health and Rights Advocacy

Community Based Advocacy

ACTION INDIA- Delhi	C/o Gouri Choudhary 5/24 Jangpura New Delhi- 110 014 Phone 011-4314785 Fax 011-4327470
AIKYA - Bangalore	C/o Philomena Vincent 377 Jayanagar, 42 nd Cross, 8 th Block Bangalore-560 082(Karnataka) Phone 080-6645930,8432363 Fax 080-6631565,attn. Aikya
ARTH- Udaipur	C/o Dr. Sharad Iyengar 67, Adinath Nagar, Fatehpura Udaipur-313 004 Phone 0294-561150 Fax 0294-561150
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- United Nations. 1995. Summary of the Programme of Action of the International Conference on Population and Development. New York: United Nations.
- VHAI. 1997. Report of the Independent Commission on Health in India. New Delhi: VHAI.
- World Bank. 1996. Improving Women's Health in India. Washington: The World Bank.

- Isis International. Women's Perspectives on Population Issues (Information kit). Phillipines: Isis international.
- Jain, A. 1998. Do Population Policies Matter? New York: Population Council.
- Kissling, F. 1997. The Vatican and Politics of Reproductive Health. London: Catholics for a Free choice.
- Lombardi, K. and C.S. 1999. Cairo+5: Telling the Stories. Washington: The Centre for Development and Population Activities.
- Ministry of H&FW. Reproductive and Child Health Programme. India: Deptt. Of Family Welfare.
- Ministry of H&FW. 1997. Reproductive and Child Health Programme Schemes for Implementation. India : Deptt. Of Family Welfare.
- Ministry of H&FW. 1998. Manual on Community Needs Assessment Approach. India: Deptt. Of Family Welfare.
- Mukhopadhyaya, S. 1998. Women's Health, Public Policy and Community Action. New Delhi: Manohar Pub.
- National Commission for Women. 1996. Development of Health facilities Among Women Belonging to Scheduled Tribe Communities. New Delhi: NCW.
- Pachauri, S. 1995. South and East Asia: Defining a Reproductive Health Package for India a Proposed Framework. New Delhi: The population Council.
- SAHAYOG. 1999. Voices From the Ground. Almora: SAHAYOG.
- Saheli Women's Resource Centre. New Delhi : Saheli Women's Resource Centre.
- Saheli Women's Resource Centre. 1997. Quinacrine: The Sordid Story of Chemical Sterilization. New Delhi: Saheli Women's Resource Centre.
- Saheli Women's Resource Centre. 1999. Enough is Enough. New Delhi: Saheli Women's Resource Centre.
- Sen ,G. et.al. 1994. Population Policies Reconsidered Health Empowerment and Rights. SIDA.
- Sethi, G. and M.C. 1996. The Reproductive Health Approach. New Delhi: Population Council.
- Sharma, R.R. An Introduction to Advocacy Training Guide. Africa: SARA.
- Shiva, V. 1993. Minding Ourselves. New Delhi: Kali for Women.
- Subhadra and Rahul. Felicitating KANSARI: Bhil Tribal Women Battle Diverse Patriarchies. Madhya Pradesh : KNV.
- UNFPA. Advocating Change Population Empowerment Development. New York: UNFPA.
- UNFPA. Coming up Short: Struggling to Implement the Cairo Programme of Action. New York: UNFPA.
- UNFPA. Population and Sustainable Development Five Years After Rio. New york: UNFPA.
- UNFPA. 1998. Population Issues Briefing Kit 1998. New York: UNFPA.
- UNFPA. 1999. Partnership with Civil Society to Implement the Programme of Action, ICPD, New York: UNFPA.
- United Nations. Report of the Ad Hoc Committee of the Whole of the Twenty First Special Session of the general Assembly.

RESOURCE SECTION

Books for further reading

This is a selection of books and reports we found useful while making this booklet

- Alcala, M. J. 1995. Commitments to Sexual and Reproductive Health and Rights for All. New York: Family Care International.
- ARROW. Changes in Population Policies and Programme Post ICPD Cairo: A Regional Research Project. Kuala Lumpur: ARROW.
- ARROW. Gender and Women's Health Kit. Kuala Lumpur: ARROW.
- ARROW. Towards Women Centred Reproductive Health. Kuala Lumpur: ARROW.
- ARROW. 1996. Women –Centered and Gender Sensitive Experiences Changing our Perspectives, Policies and Programmes on Women's Health in Asia and the Pacific(Health Resource kit). Kuala Lumpur: ARROW.
- ARROW. 1999. Taking up the Cairo Challenge- Country Studies in Asia Pacific. Kuala Lumpur: ARROW.
- Ashford, R. and C.M. 1999. Reproductive Health in Policy and Practices. Washington : Population Reference Bureau.
- Bharati, S. (ed). 1999. Risk, Rights and Reforms. New York: Women's Environment and Development Organization.
- CEDPA. 1995. Cairo, Beijing and Beyond. Washington : CEDPA.
- Centre for Reproductive Law and Policy. Cairo+5 (Kit). New York: The Centre for Reproductive Law and Policy.
- Centre for Reproductive Law and Policy. 1995. Women of the World: Formal Laws and policies Affecting their Reproductive Lives. New York: The Centre for Reproductive Law and Policy.
- Chayanika et. al. 1999. We and Our Fertility. Mumbai: Comet Media Foundation.
- Correa, S. 1994. Population and Reproductive Rights. New Delhi: Kali for Women.
- Correa, S. 1999. Implementing ICPD: Moving Forward in the Eye of the Storm. Suva Fiji: Development Alternatives with Women for New Era.
- Family Care International. 1994. Action for the 21st Century Reproductive Health and Rights for All. New York : Family Care International.
- Family Care International. 1999. Sexual and Reproductive Health Briefing Cards. Netherlands: Family Care International.
- Ford Foundation. 1997. Advocacy for Reproductive Health and Women's Empowerment in India. New Delhi: Ford Foundation.
- Germaine, A. and R. K. 1995. The Cairo Consensus the Right Agenda for the Right Time. New York: International Women's Health Coalition.
- Hardon, A. et.al. 1997. Monitoring Family Planning and Reproductive Rights: A Manual for Empowerment. London: Zed Books Ltd.
- HERA. 1998. Confounding the Critics: Cairo Five Years On . New York: HERA.
- HERA. Women's Sexual and Reproductive Rights and Health. New York: HERA.

Campaign against Injectable Contraceptives

Women's groups in India have been very vocal against the introduction of Injectable Contraceptives in the country. The campaign started in December 1984 and is still ongoing which illustrates the very dynamic and sustained nature of this campaign. During this extended period the campaign has included dharnas, sit-ins at the Ministry of Health and Family Welfare and ICMR, gherao of the Drug Controller, public interest litigation, reaching out to the public through posters, booklets songs and skits and even video. The success of this campaign can be measured by the fact that these contraceptives have not yet been made part of the Family Planning programme. For more information about the campaign please get in touch with Saheli, Women's Resource Centre.

Confronting and Engaging -The third strategic option for advocates is to engage or to confront the policy makers and implementors. For engaging the process one needs a thorough understanding of policy making processes and the ability to interact with bureaucrats and ministers at the crucial time. For confrontation the advocates need the strength of conviction and courage to stand up to even third degree measures. The media can be used as a use collaborator in such advocacy efforts.

In order to sustain an advocacy campaign there needs to be a coordination of all these three approaches which is only possible through a shared goal, mutual trust between actors and active collaboration.

Advocating for Change-Some Experiences

As has been listed out in an earlier section of this booklet there have been a number of advocacy efforts for reproductive health and rights. In this section we will introduce four different efforts which exemplify four different kinds of efforts at advocacy. Addresses of all these organisations are provided in the Resource Section.

Kansarinu Vadavno (Kn V), Khargone District, Madhya Pradesh.

KnV is an organisation of Bhil women, which is named after the Goddess of Kansari. This organisation has been involved in initiatives in the field of health, education, micro-credit etc. But the women have also started taking their demands for better health through campaigns up to the District and State Authorities. On the other hand they are also negotiating with their own men for social control of alcoholism as well as the excessive sexual demands of the men, especially under the influence of alcohol.

HEALTHWATCH

This was a national network started immediately after the Cairo Conference by a group of individuals who had attended the conference and wanted to assist in the process of actualising the PoA in India. Today HEALTHWATCH is very broad based and includes in its core-group activists, researchers, established service deliver and training NGOs, demographers and academics. The network has been involved in the last four years in creating an understanding and awareness both about the TFA and RCH as well as the post ICPD programme implementation around the country through series of consultations.

Women and Health (WAH) Network

Thw WAH! network has been active in first developing a clear perspective on women and health and once that perspective was developed has been actively involved in disseminating this understanding through training and advocacy. These training programmes which have been conducted in South and West India have now helped in creating a large number of organisations who are committed to this framework. Now the network is involved in advocating for a comprehensive women's health policy for the country.

organising communities and creating a widespread understanding and consensus on sensitive issues like women's position in society her rights and entitlements, male responsibility and participation and so on. Engaging in all these activities is not possible for any one actor and so it is essential that interested parties themselves engage in broad-based coalition building so that different people can focus on activities they are best skilled at. While advocating and lobbying with the Government authorities for both programme implementation and policy formulation has been visible, the other important task of mobilising communities for demanding their rights has not received much attention in the sphere of Reproductive Health and rights. Some of the important areas around which advocacy is important are :

- Broad based alliance building within activists, NGOs and other concerned actors
- Community based research and wide dissemination of the results
- Changing mindset of the bureaucrats and health care service providers
- Open avenues for dialogue and partnership between GO and NGOs and with the community
- Increase in bottom-up planning, ensure accountability and transparency; involve panchayats, especially the women representatives
- Increased investment in training, involve social sector experts in training; skill upgradation of health personnel;
- Improving working conditions of ANMs and rationalising her workload
- Developing a strategy for involving men
- Generating a demand from women and the community for reproductive health services and rights

Community based advocacy – The challenge for community based advocates is to help the community especially the women articulate their own reproductive health needs and demand their rights – from their families and communities as well as from service providers and the Government. This as has been pointed out earlier, is easier said than done, but a number of experiences all over the country prove that this is possible (see list provided earlier). These community based efforts need to incorporate many of the aspects outlined above like transparency, bottom-up planning, involving men and so on. At the same time these efforts need to be linked to other similar efforts and with national campaigns and movements in the same direction.

Providing the background for change – That the situation of women in our country is bad is well documented, but there are many aspects of women's health and the denial of their reproductive health which has not been adequately documented and many false notions about the status of women's reproductive health and rights persist. Similarly people in the community accept their situation unquestioningly. The challenge for research for advocacy is to bring to light these situations through thorough documentation to policy makers and implementors as well to the community at large so that they make take stock of their own situation and act accordingly. The other task of intermediary organisations is to develop alternate modules for training to prepare new advocates at all levels. These training modules may also be strategically used with Government functionaries. This possibility may sound attractive but may not be very feasible.

- Sakhi- Kerala
 - VHAI - New Delhi
- (addresses are provided in the resource section)

Advocating for policy change with the Government - Besides creating an informed community awareness on the issues of Reproductive Health and Rights an agenda which has slowly emerged is that of advocating for policy changes or for effective implementation of Government Programmes. On this count there are three different kinds of efforts which are currently being tried within the country. These three efforts are characterised by different approaches but all three are spearheaded by activists and NGOs. There are some NGOs which are involved in all three efforts.

The first effort could be broadly termed as **active conformation and litigation**. This has included successfully resisting the introduction of long-term hormonal contraceptives like Depo Provera and Norplant or for Quinacrine. On the other hand the same groups have also actively lobbied for introduction of legislation for banning sex-selective abortions in which they were successful. Many of the activists involved in these efforts belong to what is loosely called the autonomous women's health movement in India.

The second effort could broadly be called **engagement** and is being spearheaded by a network of academics, activists, NGOs, demographers called HEALTHWATCH. This network was formed immediately following the Cairo conference and has the fulfillment of the Cairo PoA as its main objective. Towards this end it has been involved in consultative processes and conductive nationwide studies. The results of these consultations and studies have been regularly shared with the Government. While there has been no explicit acknowledgment of the contribution of HEALTHWATCH in the framing of the new Target Free Approach, Reproductive and Child Health Programme or the Community Needs Assessment Approach, members of the network have been involved in influencing some of the changes in their independent capacities.

The third effort mentioned above is that of the Women and Health (WAH!) network. This is a network of NGOs which are concerned about women's health. Its activities have included **consensus building** among NGOs around the issue of a gender sensitive women and health approach, training of community level NGOs in this approach and thereafter lobby with the Government for a Women's Health Policy. The WAH! Network is very active in the southern and western states of India. The success of WAH! lies in the fact that a large number of NGOs are now pursuing a holistic women's health approach in their community based programmes and from that position of strength are willing to propose a framework for a Women's Health Policy.

Strategies for Successful Reproductive Health Advocacy

Advocating for Women centred Reproductive Health is not just a matter of getting the Government to formulate the right sounding programmes. It is a complicated issue of building bridges with the Government, service providers, media, community leaders

reforms. In recent times dowry deaths have given rise to strong voices within the women's movements decrying this inhuman practice. In the case of contraceptives there have been struggles against the introduction of long-acting hormonal contraceptives. But in the case of reproductive health in general there have been no large scale or vehement demands. In the period before ICPD, NGOs and women's groups organised a series of parallel consultations across the countries trying to take on board concerns of activist and grass roots workers. But at the same time organisations all around the country have in their own way tried to define newer ways of addressing the reproductive health concerns of women in the communities. A review of these efforts is given below.

Community based advocacy - In a country like India social systems are so strong and well entrenched that women's movements, despite being extremely vocal their impact has been often more in terms of legal provisions rather than change in people's mindset. In such a situation the importance of advocacy is two fold- raising consciousness among the community to the issue and practice of inequity as well as with state systems to enact and implement new policy. Where consciousness raising efforts are concerned in the sphere of Reproductive Health these are primarily pioneered by different community based NGOs working on this issue. Their numbers are few, and they are far outnumbered by those NGOs which are working primarily with either a very Family Planning/Population Control oriented approach or a maternal and child health perspective. Some of the more prominent organisations working on a reproductive health and rights perspective at the community level are-

- AIKYA - Bangalore
- ARTH- Udaipur
- CINI- Calcutta
- RUWSEC - Tamil Nadu
- SAHAYOG - Uttar Pradesh
- SARTHI - Gujarat
- ACTION INDIA- Delhi
- MASUM, Pune
- SEARCH, Gadchiroli

These organisations (addresses given in the resource section) are assisted in their efforts by other NGOs which have developed their core competencies in training/documentation for community based workers and organisations in implementing effective Reproductive Health and Rights programmes. Some of the more prominent NGOs providing training and Resource Support are

- AIKYA - Bangalore
- CEHAT- Mumbai
- CHETNA- Gujarat
- SAHAJ- Vadodra
- SAHAYOG - Uttar Pradesh

Section Three

Advocating for Reproductive Health and Rights in India

Reproductive Health and Cultural and Political Challenges to advocacy in India

In the recent past lot of success has been gained in getting gender, empowerment of women and reproductive health and rights incorporated at the policy and programme level of the government and that of international development organisation but in reality many of these changes remain restricted to paper and poor rural women continue to suffer multiple oppressions. The International changes have been successful in changing the language of the discourse but as far as the state is concerned, a lot of doubt remains about its intentions. There is the fear that the state has adopted the rhetoric without adopting the substance and this is even worse. The experiences over the last couple of years with regard to the implementation of programmes by the different authorities strengthens this doubt.

The other challenge in enabling women to achieve their potential reproductive health does not lie in not having effective policies or programmes, but in their implementation. It is with regard to this hurdle one has to consider the cultural traditions and biases existing in different parts of our country. Patriarchy is by and large practised in most parts of the country (except some notable exceptions), reproductive organs and functions of the women's body are considered polluted and shameful, there is a great degree of hypocrisy surrounding matters relating to sexual behaviour. Added to this there are numerous beliefs and practises concerning the smallest aspect of women's lives, especially menarche, pregnancy, childbirth, childrearing, infertility, and women's health (especially reproductive health problems). In such a situation enabling women achieve a state of health is not just a simple matter of providing services and designing IEC programmes. The challenge is to somehow change the deep-rooted centuries' old traditions and unless we realise this most efforts will not be very successful.

The problem of cultural biases is prevalent not only within communities at large, within the women themselves, but also within the service providers who are supposed to provide different social sector and health services to the community. In such a situation, just assuming that a change in programmes will affect their behaviour is being very naive. There are enough evidences in the last three years to show much of changes that have been brought about by programmes are not being implemented in the spirit intended. Advocacy efforts at the community level to change community attitudes and perceptions becomes very important in this context.

A Review Current Advocacy Effort for Reproductive Health

There is a long history of social movements in seeking a better social status for women in our country. Close on the heels of social movements has also been a history of legislative

The ANM is the worker loaded with the maximum number of tasks, yet she is under trained, hardly supervised or supported in the community, under-equipped with equipment and supplies, and has to function often in very poor living and working conditions. Yet she is expected to provide the entire gamut of health services under the RH programme. Yet, there is also a Male Multipurpose Worker, who is not accountable for much beyond condom distribution and promotion of vasectomy. Obviously, a resource is under-utilised here, especially if we take into consideration how most RH decisions in a family are taken by men, including decisions to seek referral care. This reflects an underlying gender-blindness in the entire programme, despite the lip service; perhaps following from basic lack of clarity as to 'why RH?'

A second major anomaly is the definition of RCH. Perhaps the 'donor nudging' was too strong, and the voice of women's health activists left unheard, but the GOI is determinedly going ahead with a very limited definition and calling it RCH. As a rather mathematical exposition in the TFA manual puts it,

RCH = FP + CSSM+ prevention of RTI/STD and AIDS
+ A 'client approach' to providing FW and Healthcare services.

This reductionism might be understandable in terms of using earlier familiar concepts, but it omits several significant aspects of RH, such as cancers, menstrual and post-menopausal disorders, childlessness, prolapse uterus and so forth. Further, this approach completely ignores women's lack of reproductive rights, male sexual behavior, issues of violence, access and gender. The underlying assumption, once again, is that only women who are married and in the reproductive age group will be targeted. There is no provision for dealing with unmarried or childless women, older women, adolescents or single men. The widespread gender bias which deprives women of autonomy, especially in sexual matters, is not clearly addressed anywhere even as a factor affecting strategy.

This brings us to the third major anomaly in the policy, concerning the operationalisation of the change. The modalities of decentralization are not clear, for systems of feedback and mid-course correction are absent. All monitoring is clearly top-down. Thus community participation, remains, in practice, merely participation as recipients of services, not as active agents for empowerment in RH. Further, strategies to involve key actors in the community in a consultative process are not spelt out. How, in concrete terms, is the paramedic worker going to generate community demand for services to the extent that the 'Felt Need' actually gets assessed tangibly enough to feed into the Sub Centre Action Plan?

This brings us to the fourth anomaly in the new approach: involvement of NGOs and other stakeholders. The earlier government attitude was to regard NGOs as cost effective service delivery contractors, stemming from the earlier NGO roles in charitable work. But NGO identity in India has changed towards advocacy, trainings, research and alternative development. NGOs have done pioneering work in rational drug use, alternative therapies, understanding RH, HIV/AIDs, gender and health care adolescent sexual health and so forth, which the government has not yet recognised fully. The government continues to only call in NGOs for programme implementation according to pre-designed norms, and to avoid sharing information at the planning stages. Despite the existence of a strong women's health movement in India as evinced by the number of dedicated NGOs and networks, this valuable resource has been extremely underutilised. A look at the RCH Schemes seems to belie this, for there is opportunity to be funded for innovations, and resource provision for smaller NGOs to be trained by 'mother' NGOs. Yet a closer scrutiny shows that the fundamental issue of government accountability is missing. NGOs are not invited to any platform for dialogue with government, nor do they participate anywhere in framing the Sub-centre Action Plan.

An Assessment of the post-ICPD Policy Changes in India

Positives Signs : India has undeniably taken its commitment to the ICPD POA quite seriously. The combined effects of some nudgings from donors, and internal voices demanding change has resulted in a fairly dramatic shift from a policy position held for thirty years. There has been substantial documentation of the shift, with Manuals, including Training Guidelines, detailing the changes and new components. This does provide a basis for common understanding nationwide. The intentions are laudable: Quality of Care, Bottom-up Planning Community- Need based service provision, very much in line with the ICPD outcome, as well as genuinely addressing the existing lacunae in the FWP. The components of the programme also address some of the most pressing RCH problems in the country, where women actually die of lack of these health services.

Anomalies : While granting that the Cairo document presents an ideal to be attained only after considerable struggle, there remain several anomalies in India's policy changes after ICPD. Regarding India's policy shift even from even from the viewpoint of community RH needs leaves a lot to be desired.

First and foremost the global swing away from 'demographic imperative' language was achieved at ICPD by pressure from women's groups who demanded that women's health concerns be given centrality. This resulted in accommodation of women's and adolescents reproductive and sexual health, empowerment and rights on the global agenda. However, this seems to have been left unstated in all the GOI documents. There is on the contrary, a feeling that by ensuring healthy mothers and healthy children, 'RCH is even more relevant for obtaining the objective of stable population for the country'. Moreover, using of spacing and terminal methods means "population is controlled in the short term". The TFA Manual Introduction states clearly that 'the success of the (Family Welfare) programme..... can be judged only on the basis of the reduction in the birth rate'.

While talking of a client centred demand driven approach, no clear roles is given to local women for planning or monitoring at community level. Neither is the ANM or any other worker accountable to local women. The only local women's group mentioned in the Manual is the Mahila Swasthya Sangh, which seems primarily a recipient of health and population education. The LHV is supposed to ask the opinion of community women but in absence of an active group, this may not work. Despite mainly targeting women for most activities, no systematic feedback is taken from them. As before women remain "object" of the RH programme rather than partners.

This brings up the deeper issue of whether such a radical policy shift can be instantly accommodated by such a large administrative structure as the government. Since the government was not part of the women's health movement in the build-up to ICPD, the policy announcement was fairly abrupt for the mass of medical, political and administrative leaders, service providers and members of the medical professions all of whom have the earlier 'population control' mindset deeply ingrained into them.

that there will be no more top-down imposition of method-specific contraceptive targets for health and non-health government functionaries, and all incentives for motivators or providers will be withdrawn, neither will there be assessment of any functionaries solely on the basis of contraceptive targets. What there will be instead are bottom-up planning processes, quality of care, and generation of community demand for services to make it a people's programme.

The components of the programme include mother care (including ante-, intra- and post-natal care), care of newborns, immunisation, prophylactics for anaemia and Vitamin A deficiency, contraceptive and abortion services, curative care from diarrhoea and Acute Respiratory Tract Infections (ARI), and nutrition counselling and prevention of RTI/STD and AIDs. While several components already existed earlier in the Family Welfare Programme, the new programme interventions include management of ARI, prevention of RTI/STD/AIDS, and attention to emergency obstetric care.

Manual And Training : The TFA Manual (1996) goes into a fair amount of detail to spell out services and activities, outcomes and indicators, and procedures for planning and monitoring. The need for training and effective IEC are highlighted and there are formats for monitoring and record keeping within the new approach. The concept of "Quality of Care" is also examined in fairly minute detail.

The TFA Manual was followed by the "Training Plan Guidelines" to prepare in-service district training plans (MoHFW, 1996). The Guidelines stress the need for a 'change' in mindset of the health (care) providers, and that 'it is not only necessary for health(care) providers to be technically sound but they will also have to acquire necessary communication skill..... to satisfy the clients. There is an assessment of what went wrong in earlier programs, and suggestions for a 'Continuing Education' approach utilising even monthly meetings.

NGOs : There is a significant difference between the TFA Manual and the Training Plan Guidelines. In that the latter acknowledges the existence of NGOs are seen as potential sites for skill training of ANMs, and as participants of community level trainings. The role of NGOs within the new scheme of things is spelt out in detail in the third major post-ICPD document: the manual on 'RCH Programme - Schemes for Implementation'. This document, in its chapter on NGOs, clarifies that the role of NGOs in RCH will be 'complementary in nature' vis a vis the government and sets out three kinds of activities for NGOs:

- Community level advocacy and counselling for RCH.
- Screening, Funding, Monitoring and training's of smaller NGOs for RCH programme.
- Innovative programme under RCH (Baby-friendly hospitals, Mobile RCH services, surveillance for Sex Detection Clinics etc.)

Gandhi during the emergency. As everyone knows the Emergency excesses in the field of sterilisations were one of the main reasons which brought the Government down. After 1977, family planning (now the department was renamed as Family Welfare) became a low-key activity but soon after Mrs. Indira Gandhi came back to power the voluntary sterilisation camps re-started with the new technology of laparoscopic sterilisation. Women now were the main targets for contraceptives -especially sterilisations and vasectomy figures became negligible. Method specific targets were also introduced for the temporary methods but there were incidences of gross mis-reporting because these figures were difficult to follow-up. Performance in Family Planning programmes also became a key indicator of ranking States and districts and it was included as an important feature of the twenty- point programme.

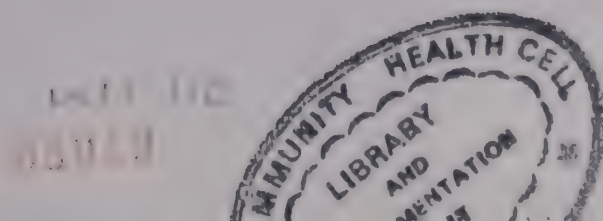
ICPD and after - The Indian Family Planning experience was coming under increasing scrutiny for its coercive methods and non-achievement of demographic goals despite achievement of targets. Following the ICPD, the Government in India (with the assistance of experts from the World Bank) started a process of change in its programme. While experiments in removing targets had started in Tamil Nadu in 1992, the Government removed targets in one or two districts in each state in April 1995. In April 1996 the Government declared the entire Family Planning Programme target free, indicating thereby that centrally determined targets were no longer going to be set. The hurriedness with which these changes had been brought about resulted in some confusions and within two years the name of the programme was once again changed to Community Needs Assessment Approach to Family Planning. Concurrently the Government following the World Bank advice reoriented the entire Family Welfare programme by incorporating the concept of reproductive health and in October 1997 it launched its Reproductive and Child Health Programme.

Draft Population Policy - Despite talking of the need to have a separate population policy from the beginning the Indian government never really got down to the actual business of framing one. In 1991 it was felt that the time has come to draft one and an expert committee was set up with Prof. M.S. Swaminathan a noted agricultural scientist as Chair. The Swaminathan Committee submitted its report to the Government in May 1994. While it is claimed that the Government has drafted its programmes in the post ICPD period by referring to this report, the fact remains that five years later we still have no sign of a Population Policy.

Features of the New Approaches - TFA, CNAA and RCH

The Target Free Approach to Family Planning. The Reproductive and Child Health Programme and the Community Needs Assessment Approach to Family Planning were all announced in quick succession between 1996-1998. They are all inter-related with the CNAA being essentially a new term for the confusing TFA. Some of the features of the new approaches are discussed below.

Components : The essential feature of the Target Free Approach (TFA) and the CNAA is



Section 2

Family Planning and Reproductive Health Policy in India

Evolution of Population related Policy and its changes in India

In the Pre-Independence period - A concern for the countries growing population was articulated by Indian leaders well before Independence. Till 1921 India's growth rate negligible and started rising after 1921. Immediately afterwards there were many local initiatives for arresting this growth. In Pune the first Family Planning clinic was started in 1923. In 1928, a neo-Malthusian league was formed in Madras, and in 1930 the Congress Government run family planning clinic was started in Mysore. In 1938 the Congress party started its National Planning Council and it had a special subcommittee looking into various aspects of India's population problem. In 1949 the Family Planning Association was started. It is but natural that with such a growing concern in all parts and sections of the country Family Planning become part of the national agenda soon after independence.

Family Planning - Early Years - The Bhore Committee recommended in 1946 that population growth would be a problem and that the Government should promote birth control. The Planning Commission soon after it was set up recognised the need for a population policy. In the draft of its first five year plan it recommended that a population policy was essential for planning, and family planning was necessary for improvement of health of mothers and children. It also accepted that the state should provide facilities for sterilisations. Clinics were considered the main vehicle for providing services. Sterilisations were accepted as a method in 1959, and in the same year incentives were given for the first time in Madras. Vasectomy was the method promoted. During the second and third five year plans suggestions were also made to include sex education, family life education, child guidance to promote welfare of the family. By the late fifties it was becoming clear that the clinic based approach was not able to reach most of the countries families and in 1963 the Government proposed that Family Planning should be promoted using the extension approach- or visiting women at their homes. Auxilliary Nurse Midwives (ANMs) were now trained to do this. In 1966-67 time bound targets were first introduced to enhance the decline in birth rates. These targets were set by the central Government and in turn passed on to lower levels- state, districts, primary health centres subcentres and functionaries.

Tyranny of Targets - The Fourth Plan (1966-74) period marked the intensification of the Family Planning efforts. On one hand the Ministry of Health was renamed into the Ministry of Health and Family Welfare, and a separate department of Family Welfare with a Secretary in charge was set up. On the other the 'cafeteria' approach started broadening the range of contraceptives offered (pills and IUD), mass sterilisation camps started and the MTP Act was passed. However the ambitious target of reducing birth rates was not achieved. In the Fifth Plan the Minimum Needs Programme was integrated with the Family Planning Programme but this was also the period of apparent anomalies. While the Indian Health Minister raised the slogan of "Development is the best contraceptive" at the Bucharest conference, forced sterilisation camps were conducted at the behest of Sanjay

- Lack of proper health services
- Lack of decision making and financial autonomy for health care seeking
- Domestic violence
- Sexual violence

There will be few who will argue that the entire list has been fabricated. If this list even in parts reflects the situation of women's health as it exists in India can the concepts of reproductive and sexual health and rights be alien?

Going beyond Reproductive Health - Developing a women's health policy

Primary Health, Reproductive Health, Women's Health - What do these terms mean, how are they different. First there was the Alma conference which talked of Universalisation of Primary Health and raised the slogan of "Health for all by 2000". Obviously there was something missing and now the Cairo conference has firmly established Reproductive Health and the goals this time have been placed for the year 2015. Now what is missing that we need to discuss Women's Health separately? Many activists agree that while the Cairo and Beijing conferences have put the issue of Gender as a determinant of health rights in the forefront, just discussing reproductive health is not enough. Also reproductive health has developed from the population perspective and not from the health side. In order to enable women enjoy the best possible health (physical, mental, social,) it is essential to discuss a separate women's health perspective which while including reproductive health will not be restricted to it. There are many other health problems of women which are brought on by the fact that she is a woman (gender roles and biology) and policies need to be framed in order to address these. There are a few countries in the world which have already framed such policies - Brazil, Columbia, Australia and South Africa is in the process of doing so. Activists in India are also trying to put together a process which calls upon the Government to do so. But it is not going to be an easy task and will need the concerted efforts of a dynamic women's movement together with a favorable political climate in order to do so.

Framers of population policies also need to seriously question the assumption that populations growth is not the only or most impotent determinant of poverty and environmental or resource depletion. Reduction of fertility rates cannot take place without concomitant improvement in other social development indicators like education and general health and gender relations. And it must be also remembered that Reproductive Health in its true essence goes much beyond just adding some additional services to existing Family Planning and MCH programmes.

Is Reproductive and Sexual Health and Rights an idea which has been imported?

There is often a tendency to label the reproductive and sexual health and rights related discussions as alien to our own culture and as being imported by feminists from the west. The reason given is that where people do not have enough to eat this kind of discussion draws attention from the many other immediate needs for survival. Unfortunately reproductive health is at the core of survival and so this argument does not hold much water. The other thing that needs to be kept in mind that while survival may be important the right to life also qualifies the quality of life that the surviving person is entitled to. Reproductive health and rights of women is a significant aspect of that quality of life. And thus in no way is a discussion on this subject less important than one on food security.

While it is true that Western ideas have played a role in drawing attention to what should be women's entitlements in terms of health and on her body at large, women from the developing countries have contributed equally with their own ideas and analyses and played their own roles in the entire struggle. The most important "western" idea is the idea of or the primacy of "self" or the individual identity which is central to the debate of rights (bodily integrity). In cultures like ours, women are socialised from early on about self denial, and this way tend to accept all forms of privations as fail accompli. Women's activists from the developing countries have developed the concept of 'self' or individual entitlements further to include the notion of social and economic needs and conditions which enable individual poor women to access their health, and rights to decision making. The entire debate of reproductive health and rights becomes extremely relevant in India when you consider the following situation of women as it prevails in our country -

- Sex selective abortion for aborting female foetus
- Lack of proper nutrition or education for the girl child
- Early marriage and child bearing
- Shame and pollution around reproductive organs and processes like menstruation
- Frequent pregnancies and childbirth
- Harmful customs and practices around pregnancy, childbirth and puerperium
- Lack of quality antenatal, intra-natal and post natal services
- Lack of safe abortion services
- High incidence of maternal mortality
- Lack negotiating power in sexual relationships
- Pressure to contracept, unwanted sterilisations
- Lack of information or choice in contraception

		informed
5. Underlying assumptions	Population size/growth is the main determinant of poverty, under-development and environmental sustainability	Poverty is due to the economic growth model of development. Focus is on meeting basic needs and not on population control
	Population control will reduce fertility	Improving women's status and providing quality reproductive health programmes will help to reduce fertility

(From : ARROW 1996: Women centred and gender sensitive Experiences: Changing out perspectives, policies and programmes on Women's Health in Asia and the Pacific. Resource Kit)

Population Policies and Reproductive Health

The concept of Reproductive Health emerged as a reaction against the narrowness of the population control mindset and its operationalisation. Now that reproductive Health has established itself as an idea whose time has come one needs to define the relevance of Population Policies. These two concepts seem fundamentally opposed to each other in some ways - population control is defined in terms of social significance while reproductive health is concerned with enabling the individual. For many the meeting point of the two is Family Planning which is a central idea in population control, and an important idea in Reproductive Health. The difference being in how it is viewed. Population control is concerned with family planning from reducing fertility and population growth while reproductive health is concerned with individual and their choices and health. Thus for this point of view the challenge for population policies is thus to enable individuals to achieve the reproductive intentions.

But there is another point of view which sees population policies in an entirely different light in the new reproductive health and rights framework. Here population policies are not concerned with the reduction or augmentation of numbers but in the quality of life of all segments of populations – especially the ignored sections of the population.

No matter what the point of view is the challenge of population policies is to ensure that certain principles are incorporated, some of which are given below-

- the principle of equity and social justice
- the principle of autonomy and self determination of the individual - women and men
- that individual have individual rights and social responsibilities - women and men towards each other and children's health and well being.
- The principle of participatory democracy - engage the most marginalised in the decision making process.
- The principle of accountability and transparency.

	increase of fertility and population	Increase women's control over their bodies and ultimately their lives
	Improve women's and children's health and family welfare (secondary goal)	Change socio-economic conditions which are barriers to the exercise of reproductive rights (e.g. women's legal status, education, poverty level, Decision making power in the household, choice of whether and when to marry)
4. Ethics/values	Reproduction is primarily a social function	Women have the individual rights and the social responsibility to decide whether, and how and when to have children and how many to have: no woman can be compelled to bear a child nor be prevented from doing so against her will
	Demographic goals of a country are more important than the human rights of individuals	Women have the right to choice within a human rights framework Men also have a personal and social responsibility for their own sexual behavior and fertility, and for the effects of that behavior on their partners and their children's health and well-being The fundamental sexual and reproductive rights of women cannot be subordinated against a women's will, to the interests of partners, family members, policy makers, the state of any other actor Due to biology and gender role and responsibilities, women have a greater right to make fertility related choices Women can be trusted and must be respected to make their own reproductive decisions when fully

Health Programme which was designed with the assistance of the World Bank

Political Parties and Leaders - The role of national political parties and leaders in the framing of national policies are obvious. Very often political will decides the kind of population policies are in place within a country. For examples within India one has to consider the Emergency period forced sterilisation and the target-oriented regime of India's Twenty Point Programme. Even today the lack of political will makes mockery of the provisions of the new Community Needs Assessment Approach and the Reproductive and Child Health Programme.

Women Centred Reproductive Health and Population Control/Family Planning Approaches Compared

The change that the two UN conferences recommend has to be operationalised in terms of an effective approach. The table below gives a comparison between the conventional Population Control mindset and the newer Reproductive Health approach in terms of the conceptual understanding and assumptions.

Area	Population Control/FP Approach	Women-Centred RH Approach
1- Rationale	<p>The most important aspect of women's health is pregnancy, childbearing and fertility. Women's health is very important as it affects the health of children</p> <p>When women have fewer children who are better spaced, women's health and status will improve</p>	<p>Women's health has not automatically improved by focusing on contraception and maternal health- maternal mortality rates can still be high even though use of contraceptives has risen</p> <p>With a narrow family planning and maternal and child health care focus women's other health problems are neglected (e.g. unsafe abortions, RTIs, STDs, cancer and health effects of violence against women.</p>
2- Definition of women's reproductive health	<p>A narrow biomedical meaning as maternal health or the health of women of reproductive age, focusing on birth child bearing without death of disease, and on contraception</p>	<p>A broad understanding which is centred on the right of women to make their own autonomous choices about reproduction and sexuality, and the right to provision of services of a high standard which are women-centred (based on women's experiences and needs)</p>
3- Goals	<p>Demographic reduction of</p>	<p>Improve women's health including their reproductive health</p>

maternal mortality rate below 125 per 100,000 live births and below 75 per 100,000 live births by 2015

Alongside the UN conferences on Population were the conferences on women- Mexico City 1975, Nairobi 1985 and Beijing 1995. These conferences too have made important recommendations about the status of women including their health. Some of the important principles which these two conferences (Cairo 1994 and Beijing 1995) upheld were-

- Gender equality and equity and women's empowerment are essential
- National strategies have to be developed to ensure universal access to all individuals a full range of reproductive and sexual health services
- Sexual and Reproductive health has to be considered within a primary health care context
- All barriers to women's access to health services have to be removed
- Reproductive health interventions have to be redesigned taking into consideration women's multiples roles
- Male responsibility and equal partnership has to be promoted
- Efforts to increase women's awareness of their rights – including sexual and reproductive rights has to be supported
- Transparency and accountability has to be ensured

The interested reader will find details of the recommendations of the two relevant conferences – Cairo and Beijing in many interesting documents some of which are mentioned later.

Other Actors Influencing Reproductive Health Population Policies

Religions - Religious doctrines and religions leaders are often serious critics of many population or reproductive health policies. On the one hand religions are often adverse to artificial forms of contraception, while on the other they also try to stall any form of deviation from their accepted codes of reproductive and sexual behavior. The position of women is also very clearly delineated in most religions and attempts at changing this status is sometimes scene as a attempt to undermine the religion. Most religions tend to take a natalist, anti abortion stance and this seriously hinders policy formulation and implementation in many countries. The Roman Catholic Church has played a particularly reactionary role in the entire ICPD and its follow-up process. The Vatican has an observers status in the UN and using this official position it often stalls debates and discussions which it perceives as being against its teachings. Other religions play significant roles within individual countries.

International Agencies and Donors - UN agencies usually follow the agenda that has been outlined at the different UN conferences and this dictates the funding they provide to countries. Other International agencies/donors like World Bank, USAID and even Population Council are also known to influence reproductive health and population policies in our own country. Examples from India include the Reproductive and Child

- Successful campaigns against sex selective abortions

International Conferences, Population policies and Reproductive health

The UN has held a series of conferences which have had an important bearing on the evolution of ideas of reproductive and sexual health and rights. The first one, which was not strictly on the issue was the International Human Rights Conference held in Teheran in 1968, which introduced the concept of the rights into the realm of contraception and family planning. The first conference devoted exclusively to the issue of population was the World Population Conference in Bucharest in 1974. In this conference the dominant view was that development was the best contraceptive and importance was given to socio-economic development as a major force in reducing population growth. The next population conference was held ten years later in Mexico City. By this time women's health activists managed to include some women's issues within the World Population Plan of Action – emphasising linkages between high fertility and lack of education, health care and employment opportunities for women and their low status. But this document also stated that government should make family planning measures widely available, shifting the focus to family planning programmes. The period between 1984 and 1994 when the ICPD was held, was a period of great challenges to the traditional thinking on population. Women's health activists all over the globe drew attention to the effect of these programmes on women's health and their presence in large numbers in Cairo ensured that the Cairo Programme of Action reflected many of their concerns. The changes in thinking that the Cairo process has brought about is being hailed as a 'paradigm shift'. The shift from population control to individual well being which has been outlined earlier.

These International conferences have played a major role in the way countries' population policies are framed. While the discussions and debates in these conferences reflect those which are ongoing within official circles within different countries, the parallel NGO meetings are increasingly providing spaces to activists to react and interact with official delegates and get their concerns heard. Once the official document/recommendations gets ratified, individual countries are expected to change own policies in lines with the principles of this agreement. In case of the ICPD the document is known as the Programme of Action (PoA) and it is to form the guidelines for countries for the next twenty years. Some of the major goals from the ICPD PoA are as follows:

- By 2015, the PoA advocates for a universally available family planning programme for everyone in the world
- By 2005, all countries should attain life expectancy at birth greater than 70 and by 2015 all countries should attain life expectancy at birth greater than 75
- By 2015, all countries should achieve infant mortality rate below 35 per 1000 live births
- By 2005 those countries with intermediate levels of maternal mortality should achieve a maternal mortality rate below 100 per 100,000 live births and below 60 per 100,000 live births by 2015
- By 2005 those countries with the highest levels of maternal mortality should achieve a

of Discriminations Against Women (CEDAW) was also ratified. The initial impetus for a separate movement for women's health started in Europe and North America in the 70's. In different places women had started feminist information centres, women's health centres, publication of specialised women's health related books and materials, campaigns against sterilisation abuse and abortion rights, and against baby food producers and so on. The first International Women and Health Meeting was convened by European and North American women but subsequent meetings have all been attended by women from developing nations in great numbers.

These meetings allowed women from all over the world to debate on a wide variety of issues and also to join together into a united political force. Women from the developing nations have been playing an increasingly important role in all the deliberations regarding women's health and rights. DAWN (Development Alternatives with Women for a New Era), a network of women researchers and activists from the developing nations has been at the forefront of the international women's health movement for a long time. Other influential networks included the International Women's Health Coalition (IWHC), WGNRR (subsequently disbanded), WEDO, LACHWHN and so on. Today there are a large number of organisations and networks at the national (in many countries), regional and international levels and they are working in synergy to enable women around the globe achieve their health potentials and rights.

While the actual situation of women's health is different in different countries, the common thread that unites their different situations is the lack of control women have over their health, their sexual lives, their own bodies and this external control takes many forms. Thus in India women had to face forced sterilisations, in other countries it is the pressure of pro-natalist (against contraception or abortion) policies, while in still others forced marriages and honor killings make a mockery of women's rights. The basic message of the women's health movement is the same every where and includes- access to quality health care services, particularly reproductive health services; safe and effective contraception and abortion services; respect for women's reproductive rights. The final demand is that the design and implementation of all services should be done keeping in mind the women's health needs and demographic objectives. Women's health activists have raised these issues persistently at various international fora including UN conferences. It may be argued that as a result of these persistent advocacy efforts a large number of these demands have been met through the Programme of Action adopted at the International Conference on Population and Development at Cairo in 1994.

Box – Some important gains made by / achievements of women's health activists around the world

- ICPD PoA
- Women's Health Policies in Brazil, Columbia and Australia
- Visibilising the morbidity from Reproductive Tract Infections in women
- Abortion law reform in many countries
- Successful campaigns against harmful contraceptives – injectables and vaccines

difficult this can be. This simple advice does not take into consideration essential factors like availability of vegetables, women's social position, economic condition of the family, and the prevalent myths and beliefs around women's diet and so on. Among the different cultural factors one of the most important one is gender roles and relationships (and power distribution) between men and women.

This understanding that health is determined by socio-cultural factors as well has slowly emerged over the years. Reproductive health is one area where socio-cultural factors are even more predominant, and gender roles and power relationships very clearly defined. In such a situation a population control and maternal health approach becomes very inadequate to address the actual health concerns of women.

Box – Adverse effects

Some of the consequences of having a population control oriented policy and programmes:

- Pressure for undergoing sterilisation – denial of human rights
- Health repercussions of hastily done sterilisation operations in makeshift camps – infections, intestinal adhesions, high failure rates, even death
- Inadequate attention to contraceptive safety- inadequate screening and follow-up
- Health services do not have provisions to deal with women's genuine health problems
- Poor quality of curative services

The International Women's Health Movement

The changes in the population control mindset to a broader Reproductive Health framework was to a large extent, due to the continuous critique of established policies by the International women's health movement. The International women's health movement started in the late 1970's challenging the basic premise of population control. The central logic of the challenge was that individual women's health and rights of concern rather than population control in the so-called greater interest of society. While there was no one international women's health movement, it developed in differing regions of the world differently, there were (and still are) many common platforms where women's health activists join together in expressing their common concerns.

The development of the International women's health movement has to be seen in conjunction with the larger women's movement. The UN declaration of Human Rights (1948) unequivocally affirmed the equality of the sexes. In 1968 the International Human Rights Conference in Teheran the concept of human rights was applied to the issue of family planning. Women's situation and condition became a central issue of international debate after the launching of the women's decade in 1975. All the while feminists were critical of the narrow population control mindset and policies. The International Women's Year Conference at Mexico City (in 1975) was an opportunity for women to place their reservations on the international stage. In 1979 the Convention for Elimination of all forms

Section 1

Understanding The Evolution Of Reproductive Health Related Policies

The need for the change from Population control and Maternal Health

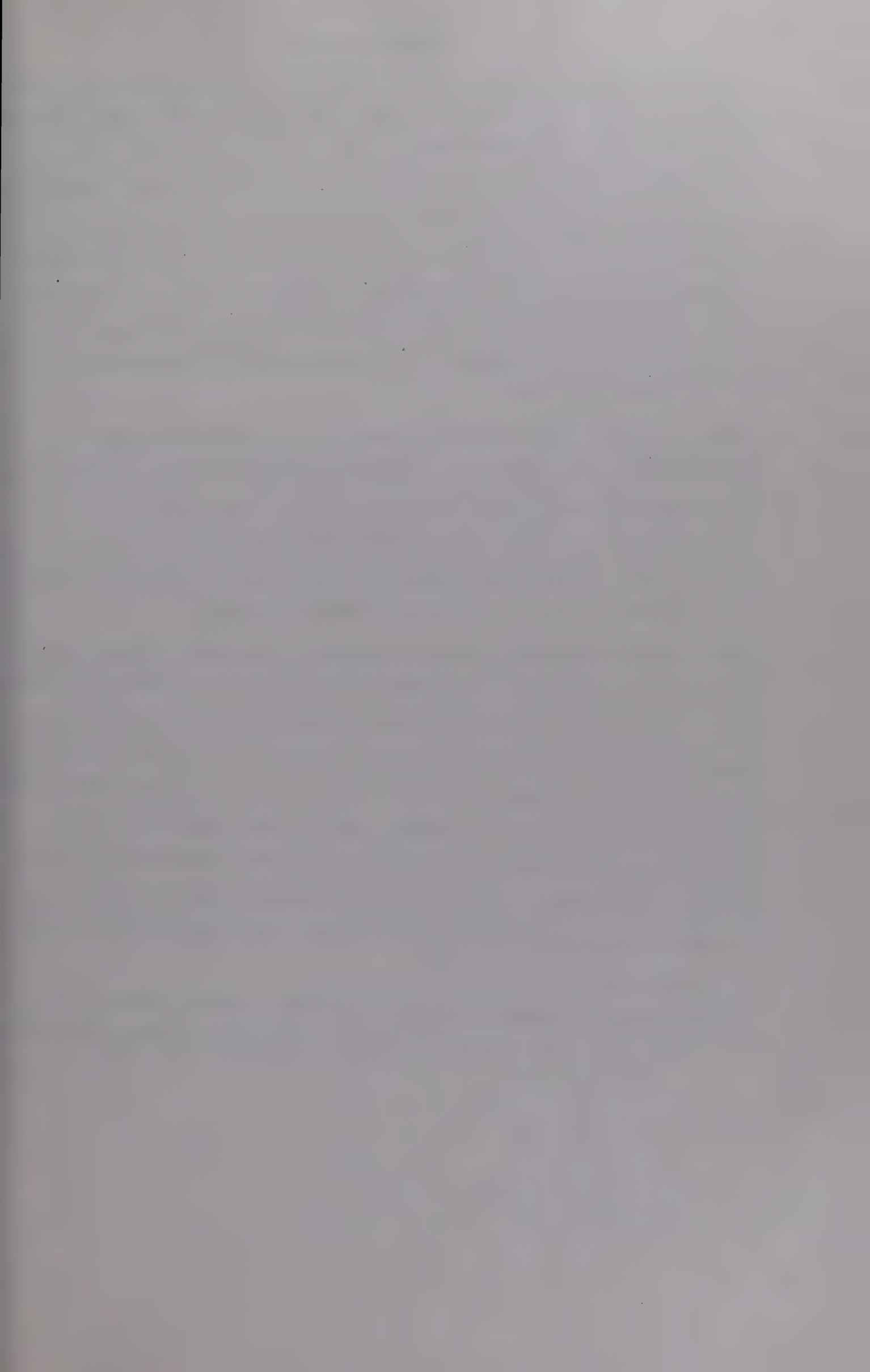
If one considers the situation in India, programmes and policies for population control and maternal health have been in place for over fifty years. Even if these did lead to some decline in population growth rates their impact on women's health was negligible. In fact it can be successfully argued that these have adversely affected the health and status of women. In India, despite such programmes the Maternal Mortality Ratios (MMR) remain as high as over 400 per 100,000 live births. In countries like Indonesia, MMR was as high as 450 despite the fact that contraceptive prevalence was over 50% of all married women. Besides this, these narrow programmes failed to address the many reproductive health problems of women. Table one provides a summary of the principal health concerns of women.

Table 1

Category of health problem	Numbers world wide/year
Unwanted pregnancies	80 million
Unsafe Abortions	25 million
Severe maternal morbidity	20 million
Maternal deaths	585 thousand
Women with invasive cancers	2 million
STDs	50 million
Maternal anaemia	58 million
Beating by male partner	20 – 30% of women
Depression	2 to 3 times more frequent in women

(Source : Sen, Germain, Chen eds – Population Policies Reconsidered and ARROW Resource Kit , 1996)

It is clear from this table how little can actually be addressed by programmes focussing on population control and the limitations only having a maternal health focus. In addition to ignoring some of the most important women's health problems the earlier approach had another major limitation. This limitation is related to how the system views women's health problems. The conventional approach had (and to a great extent this is the order of the day even now) a very bio-medical understanding of health- meaning health was viewed as a result of factors like nutrition, susceptibility to diseases, physical , chemical or biological factors and so on. Having understood health in bio-medical terms the solutions consisted of bio-medical interventions as well. Thus anaemia was considered a result of iron –folic acid deficiency and iron-folic acids and green leafy vegetables were considered the answer. This approach totally misses out on the number of economic, social and cultural factors which influence health. Any one who has tried to tackle anaemia in the village by dispensing advice on green leafy vegetables and iron tablets will appreciate how



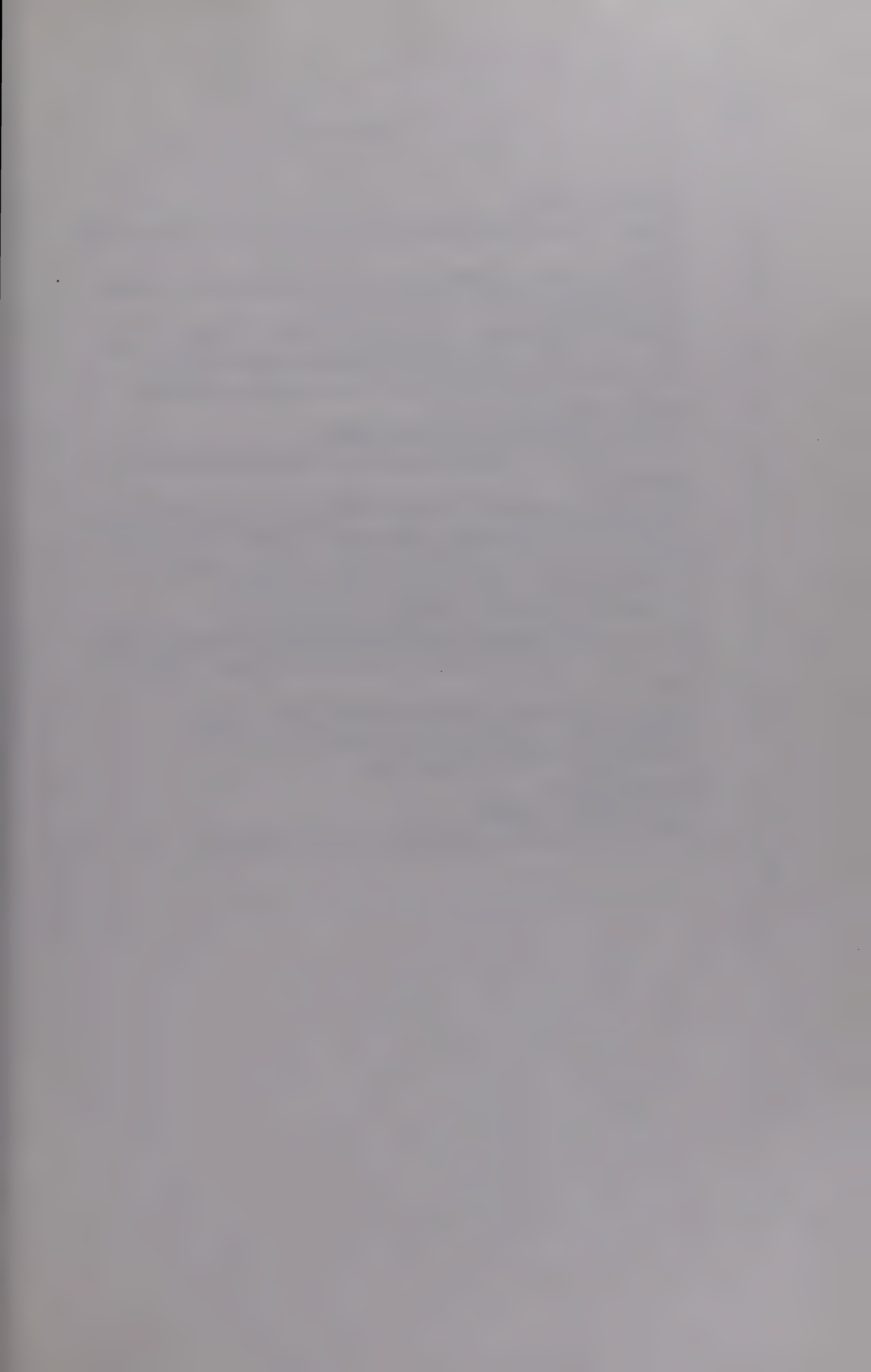
INTRODUCTION

Reproductive health policies are a follow-up on Population and Family Planning policies. India is well known as the first country to have started a state sponsored Family Planning programme in 1951. Since the beginning the programme had a strong concern for controlling India's rapidly growing population. Side by side there evolved the Maternal and Child Health (MCH) programme which was concerned with the health of mothers and their children. While in the initial years of the Family Planning Programme men were the main acceptors of permanent methods, the programme slowly changed its nature to one that more or less exclusively targeted women for sterilisations. In this situation women were important as long as they were pregnant or had delivered recently or as potential cases for family planning. And this state of affairs was not unique to India. In many countries around the world women's health issues were largely ignored while many of their reproductive health functions were controlled by different policies pertaining to Family Planning or to abortion.

Women all over the world were slowly realising how state policies were against the interests of the health of women and a movement was slowly built up to challenge this neglect of women's health, especially their reproductive health. The culminating point of this dialogue between the women's health activists and states took place at the UN sponsored International Conference on Population and Development at Cairo in September 1994. The resultant Programme of Action is the commitment for all signatories on the document (states) to slowly change their countries policies relating to reproductive health. Changes in Indian policies are also the result of this process.

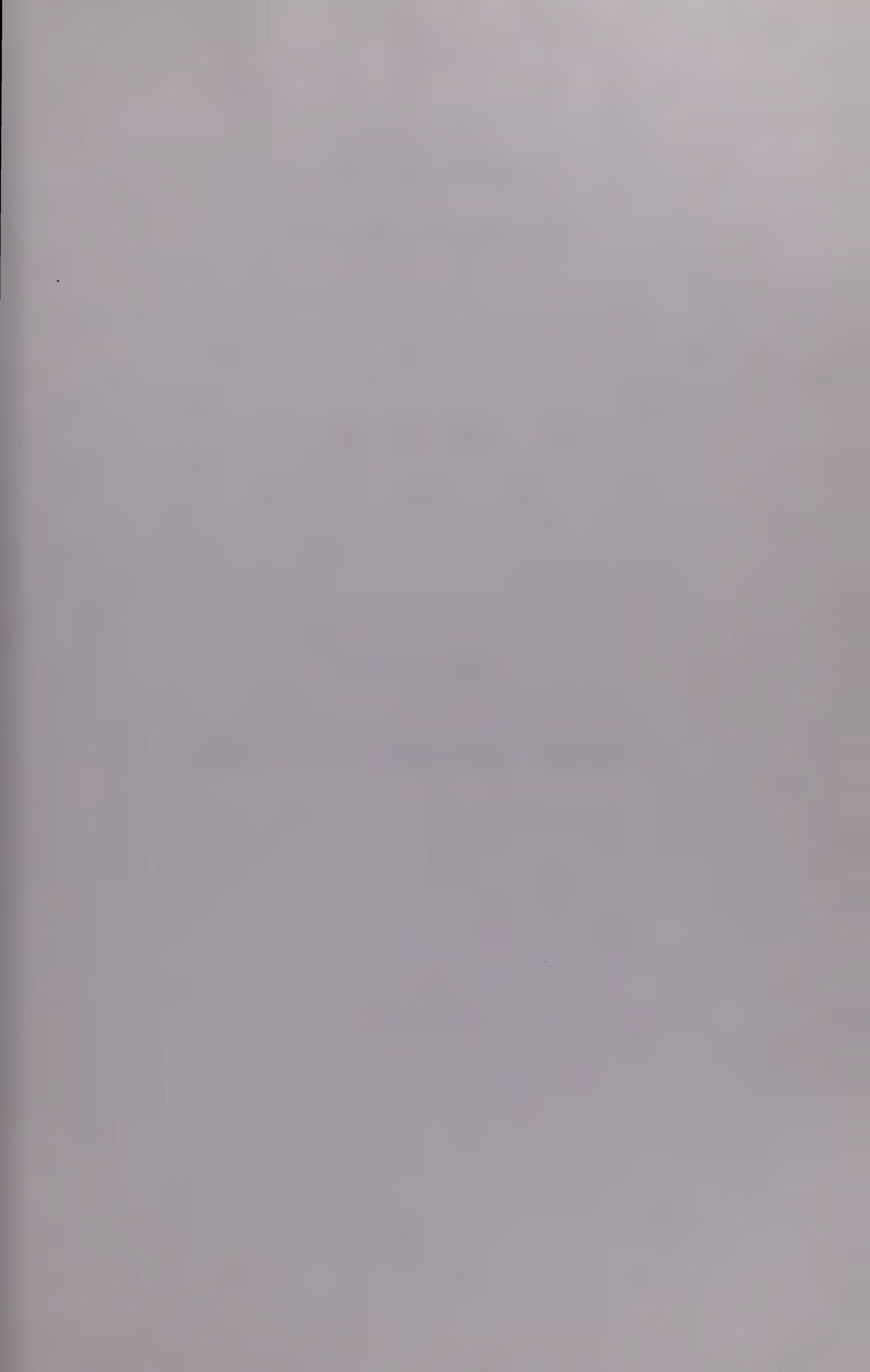
Changes that have taken place in our country in terms of policy have not always been a result of a benign and concerned government. People have for a long time expressed their own concerns and put pressure on the government for initiating policy and legislative reforms. The low socio-economic condition of women in the country has always been a major reason for social movements in the country. Some of the first successful advocacy efforts for securing women some rights had been the ones to *sati* (burning widows on the funeral pyres of their husbands) or for widow remarriage which took place through legislation over a hundred and fifty years ago. Other successful efforts in more recent times have related to legislation concerning the minimum age at marriage and for dowry related violence. Unfortunately, the social forces which perpetuate many of these inequitable systems within society are very strongly entrenched, and even legal measures have often not been very successful. Advocacy efforts towards reproductive health and rights also need to be seen in this context.

This section of the Resource Pack will present the changes that have taken place in the evolution of policies concerning reproductive health as well as how advocacy efforts both at the international sphere as well as within India have affected these processes.



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UNDERSTANDING
REPRODUCTIVE HEALTH

A Resource Pack

Booklet – Three

REPRODUCTIVE AND SEXUAL RIGHTS

SAHAYOG

	Sama, J-59, Saket, New Delhi 10017, Phone -011-696 8972 Email- magicLF@del.vsnl.net.in
HEALTHWATCH	C/o Vimala Ramachandran, 10 Vivekananda Marg, Jaipur -302001, Rajasthan Pn 0141-360158 Email-vimalar@jp01.dot.net.in
ACASH	Servants of India Society Building 2 nd Floor, Opp. Harkisandaas Hospital, V.P. Road, Girgaum, Mumbai-400004.
AIDAN	C/o Mira Shiva, A-60 Hauz Khas, New Delhi -110016.

International Organisations

There are a number of groups working on the Health and Rights Approach, outside the country, contact information of some of these is given below:

HERA	C/o IWHC, 24, East 21 st Street, 5 th Floor, New York, NY 10010, USA. Ph - 2112-979 8500 Email - hera@iwhc.org
DAWN	C/o Vanita Nayak Mukherjee 429 Prasantha Nagar, Uloor Trivandrum Phone 0471- 442935 Fax 0471- 447137 E-mail - vanita@md2.vsnl.net.in
WEDO	355 Lexington Avenue, 3 rd Floor, New York, NY 10017-6603, USA. Ph-212-973 0325 Email - wedo@igc.apc.org
Catholics For A Free Choice	1436, U Street NW, Suite 301, Washington DC, 20009 USA. Phone 202-332 7993 Email- cffc@igc.apc.org
Centre for Reproductive Law and Policy, New York	120 Wall Street, New York NY 10005, USA. Ph-

Struggles against violations

Forum For Women's Health, Mumbai	c/o Swatiya Manorama, 9. Sarvesh, Govind Nagar, Thane (East), Maharashtra, 400 603 Tel.5423532
Saheli, New Delhi	Unit Above Shop 105-108, Defence Colony Flyover Market (Southside), Defence Colony, New Delhi 110 024 Tel. 4616485 (Wed & Sat)
Jagori, New Delhi	C – 54, South Extension Part II, New Delhi Tel.- 011- 6257015 Email- system@jagori.unv.ernet.in
Sakshi, New Delhi	B-67 First Floor, South Extension Part I, New Delhi- 110 049 Phone 011-462 3295 Fax-011 -4643946

Advocacy with Community, State, Legal System

Saheli	See above
Forum For Women's Health	See above
SAHAJ	1, Tejas Apartments 53, Haribhakti Colony, Old Parda Road Baroda-390 018 Phone 0265-340223 Fax 0265-330430 Email - sahaj.wcost@m l.sprintrpg.ems.vsnl.net.in
CEHAT	2 nd Floor, BMC Maternity Home, 135 Military Road, Bamandaya Pada, Marol, Mumbai -400059 Phone -022-851 9420
WAH!	C/o CHETNA, Lilavatiben Lalbhai's Bungalow, Civil Camp Road, Shahibaug, Ahmedabad -380004, Ph - Email- chetna@icinet.ernet.in(?)
SHODHINI	C/o N.B.Sarojini,

Kumar, R. Reproductive Rights As Human Rights: Studies in the Asian Context. Hamilton: University of Waikato.

Kumar Radha. 1997. The History of Doing: New Delhi ; Kali for Women

Lindahl Katarina. 1995. Sexual and Reproductive Health and Rights in relation to ICPD 1994 .Sweden. RFSU.

Petchesky, R.P. and K.J. 1998. Negotiating Reproductive Rights. London: Zed Books Ltd.

Rehman Anika, Raghuram Shobha. 1995. Rethinking Population - Technical Report Series 1.4 Bangalore . HIVOS, and New York. CRLP

Semler, V.J. et.al. 1998. Rights of Women. New York: The International Women's Tribune Centre.

UNFPA. 1998. Ensuring Reproductive Rights and Implementing Sexual and reproductive Health Programmes Including Women's Empowerment, Male Involvement and Human Rights. New York: UNFPA.

UNFPA 1999. Violence Against Girls and Women - A Public Health Priority: New York: UNFPA

Voluntary Health Association of India. 1993. Women and Health: Issues relating to Sex determination Testing. New Delhi: Voluntary Health Association of India.

Whelan, D. 1998. Recasting WID : A Human Rights Approach. Washington: International Centre for Research on Women.

Resource People and Organisations:

Within India, the RSR approach has included work on support systems, on struggling with the state and legal system when rights have been violated, and on advocacy, with the community, with the government, and the legal system.

Some people and organisations include:

Support systems:

TARSHI, a telephone helpline in New Delhi, on Reproductive and sexual health and rights.	Talking about Reproductive and Sexual Health Issues (TARSHI), 49, Golf Links, 2 nd Floor, New Delhi 110003 Pnones – 011-462-2221, 4624441 Email-radhi@unv.ernet.in
RAHI, a centre for survivors of CSA and incest	Recovering and Healing from Incest (RAHI), M-79, Greater Kailash-II, 2 nd Floor, New Delhi 110048 Ph- 011-6238466, Email – rahisupp@del2.vsnl.net.in

RESOURCE SECTION

Further Reading

The following books and reports were useful in preparing this booklet

- 1995. Global Report on Women's Human Rights . Washington Human Rights Watch
- Akhter, F. et.al. 1991. Declaration of Comilla. Dhaka: UBINIG.
- Anthony M.J. 1996 . Women's Rights : New Delhi Hind Pocket Books
- ARROW. 1994. Towards Women-Centred Reproductive Health - Part 1
Kuala Lumpur. ARROW,
- Asian Forum for Human Rights and Development, The. 1997. Reports of a Consultation on Reproductive Rights and Human Rights: A Challenge for Human Rights Activists. Bangkok: The Asian Forum for Human Rights and Development.
- Canadian Women's Committee on Population and Development . 1996. Bill of Rights for Contraceptive Research, Development and Use. Canada: Canadian Women's Committee on Population and Development .
- Capoor, I. Et.al. Realizing Gender Inequality and Empowerment for Meeting Women's Reproductive Rights. Ahmedabad": CHETNA.
- Centre for Reproductive Law and Policy, The. 1999. Silence and Complicity: Violence Against Women in Peruvian Public Health Facilities. New York: The Centre for Reproductive Law and Policy.
- Centre for Reproductive Law and Policy, The. Reproductive Freedom Around the World: Reproductive Rights in the Refugee Context. New York: The Centre for Reproductive Law and Policy.
- Coordination Unit. 1995. Indian NGOs Report on CEDAW. New Delhi. CU
- Dutta, B. 1997. Advocacy for Reproductive Health and women's Empowerment in India. New Delhi: Ford Foundation.
- East and South east Asian Women and Health Network. 1996. On Our Own terms: Building Trust and Unity on Women's Health and Reproductive Rights from the Perspective of Asian. Philippines: East and South east Asian Women and Health Network.
- Gomez, A. and D.M. 1998. A Human Rights Perspectives: Women, Vulnerability and HIV/AIDS. Chile: LACWHN.
- Gupta Anuja . 1998. Voices From the Silent Zone New Delhi: RAHI
- Gupte, M. et.al. 1997. We Shall Bring in the Dawn: Women Resisting Alcoholism. Pune: MASUM
- Hardon, A. and E. H. 1997. Reproductive Rights in Practice: A Feminist Report on Quality of Care. London: Zed Books Ltd.
- Hardon, A. et.al. 1997. Monitoring Family Planning and Reproductive Rights: A Manual for Empowerment. London: Zed Books Ltd.
- Heise, L. et.al. 1995. Sexual Coercion and Reproductive Health: A Focus on Research. New York: Population Council.
- HERA. 1998. Women's Sexual and Reproductive Rights and Health: HERA Action Sheets New York; HERA
- Jayawardena, K. and M. De A. 1996. Embodied Violence: Communalising Women's Sexuality in South Asia. New Delhi: Kali for Women.

Areas for Research :

- More information is needed on various forms of violations of RSR, the consequences both physical and mental, and the effectiveness of support services provided.
- Investigate the links between violence against women and reproductive health, like safe motherhood, unsafe abortion, incidence of miscarriage, contraceptive use, AIDS/ STD prevention and so on.
- Incorporate data on violations of women's RSR in health data and crime statistics compilations .
- Research on male contraceptives, women- controlled barrier methods, especially for disease prevention, on contraceptive safety

Law and Policy Advocacy:

- Develop networks of women's organisations to promote recognition of and monitoring of RSR
- Reform court systems and procedures to enable women to testify more easily, especially in cases that involve someone who has considerable power over them (such as husband or male family members)
- Reform existing laws to eliminate sexual violence, including rape within and out of marriage, and in situations of armed or communal conflict, CSA, trafficking and female foeticide/ infanticide.
- Enforce laws that regulate age at marriage and sexual activity to allow for informed and consenting relationships.
- Remove reservations to human rights instruments such as CEDAW (the GOI has a reservation on 'interfering in marriage or other cultural institutions').

Organisations working on Reproductive and Sexual Rights

A detailed list of organisation working on the issue along with their addresses is provided in the Resource Section.

- Given women's reluctance to report the abuse they have been suffering, it is up to health service providers to be keenly alert to the possibility that their clients have been abused. Many of the consequences of violations of RSR such as trauma, unwanted pregnancy, abortion complications, miscarriages and STDs are likely to come up before service providers. It is imperative that they understand these rights and are motivated to monitor their violation by collecting legal evidence for prosecution. It is also imperative that they ensure privacy, confidentiality and sensitive treatment during examining and counseling. For this RSR should be incorporated in the training courses.
- Set up hotlines, crisis centres, shelters and rehabilitation homes which can be accessed by women whose rights are being violated. It is imperative that these provide a secure, non-judgemental, friendly atmosphere so that women start healing from their emotional trauma.

Educational Interventions:

- Adolescent boys must be taught that violations of women's rights is not part of male prerogative, and enabled to develop a concept of male- female relationships that are not based on inequality and power imbalances, but are mutually respectful and harmonious. It is also important to work with adult men on this through social norm setting in communities.
- Both boys and men should learn about their responsibilities in women's reproductive lives, especially about preventing unwanted pregnancy and disease and also about when to seek out referral health services.
- Sexuality education has to be provided at all age groups (no children are too young, given the reality of CSA) that affirm the principles of gender equality and bodily integrity, as well as inform about RSR. This has to be provided in both formal and informal education, and through all possible youth groups. The positive aspects of sexuality need to be highlighted, rather than projecting only the need for preventing disease and pregnancy. Moreover, it should not be prescriptive: instead it should encourage youth to develop a sense of responsibility about their bodies and their partners.
- Sexuality education should include aspects of reproductive and sexual health, the fact that women's reproductive rights are human rights, the fact that the man's sperm determines the sex of the child, about where to access services, how women can protect themselves from harm, women's right to decide about sex, and what to do if RSR are violated in any way.
- Training and education on RSR is also urgently needed for health service providers, educators, lawyers, police and judges.
- Media persons also need to be sensitised to portray violations of women's rights responsibly, with full confidentiality, without sensationalising them, but ensuring that the public concern is aroused.

Section Three

Programmatic Implications For Working On RSR

Work for Reproductive and Sexual Rights may be done at several levels, such as services, education, research, law/policy advocacy and so forth. It is distinctive in that the 'rights approach' addresses the question of women's entitlement - entitlement to health, especially reproductive and sexual health, and the responsibility of social institutions to ensure those entitlements, including the family, the community, the state and all its machinery and so forth. The 'rights approach' means that women's rights are human rights.

Unfortunately, most of those working on a 'rights approach' remain occupied in fighting against rights violations, and demanding redressal for the wrongs that have been perpetrated against women by various social institutions, starting right from the family. This is a protracted and exhausting struggle, for many of these wrongs have been done from the assumption that women have no rights at all, in fact they are seen as less than human, because they are not men. Addressing the legal system or the state for redressal of wrongs is often futile, for these institutions do not have the 'rights perspective' to begin with, and tend to offer paternalistic protection to women at the most.

It is therefore important to work towards building a widespread understanding of women's rights as human rights, and this has to be done not just with those who violate women's RSR, but also with women themselves. This is because a right cannot be exercised or demanded if the person is not aware of it to begin with. However, it must be kept in mind that work which addresses very personal questions of sexual abuse at home, domestic violence, sexuality, sexual relations and reproductive relations between partners will never be as acceptable as work which tackles 'external' issues like lack of water, education, housing, healthcare, and so on, which are problems in the public sphere. This includes acceptability even with women, who are the suffering class!

Given below are some ideas for working with RSR through services, education, research or advocacy.

Providing Services:

- Ensure access for all women to high quality reproductive and sexual health services, regardless of age, marital status, income or sexual orientation. This would mean actively reaching services to currently underserved groups such as adolescents, single women, sex workers, women who/whose partners have undergone sterilisation, post menopausal women and survivors of abuse.
- Services should at the least include skilled care during pregnancy, delivery and post partum, contraceptive choices including user-controlled and barrier methods, prevention, diagnosis and management of infertility/ reproductive tract problems/ STDs/ reproductive system cancers and safe abortion services

However, these are more like prisons, and inmates are treated as 'bad' women who have pursued a socially unacceptable profession. As such, there is very little scope for humane psychological and economic rehabilitation.

If we look at domestic violence in India, one horrific form that has attracted public attention since the seventies is violence related to demands for dowry from the girl's family, even to the point of murder. Despite the Dowry Prohibition Act (1961) and the Crime (Women) Cell which had been set up in 1985 (as the Anti-Dowry Cell), the only improvement is that more crimes are being reported, which does not say much for the actual decrease in the incidence of such violence. Apart from these is general routine inter-spousal violence. It is prevalent to the point that it is accepted by all concerned as something the husband definitely has the right to do. In several areas it is connected to alcohol abuse by the men. The Criminal Law (amendment) Act of 1983 makes cruelty to a wife a cognisable, non-bailable offence, and includes mental as well as physical harassment. However, since women usually cannot visualise any other options besides living with their husbands, this law is not used as often as it could have.

Rape is one of the most common and frequent crimes against women in India. It includes the categories of landlord rape, police/custodial rape, caste rape, army rape, communal rape, marital rape, rape of sex workers, of children and family members. There are incidents of mass rape, of an entire community of women, and of course individual rape. However, rape remains an extremely under-reported crime. Since most, if not all rape is an assertion of power and rights over the women concerned, aiming to hit at their most vulnerable sense of 'honour', it is not surprising that women and their families often attempt to cover up the incident to avert the stigma. Moreover, rape law in India insists that only penile penetration constitutes rape and demands proof of guilt; all other forms of sexual violation are termed as assault, which is a lighter offence. It is only in custodial rape that the onus of proof is on the accused. Then again sex with minors of 16 years or below is taken as rape, but the law contradicts itself in that if a man has married a girl of 15 years or more, he can legally have sex with her (although the legal age at marriage is 18!). Another serious issue is of women in situations of armed conflict such as in the North East and in Kashmir. Civil rights have been suspended: the army has the authority to enter people's homes to flush out insurgents, and has raped and assaulted women with impunity.

undergo foetal sex testing and abort any number of female fetuses because of social pressure to give birth to sons. And yet, if she undertakes an abortion for contraceptive failure or coerced sex, she is unable to speak openly about it for fear of social disapproval.

The incidence of child sexual abuse (CSA) and incest has remained shrouded in secrecy and silence for long, but a recent study of 600 English speaking, upper or middle class women mostly living in the metropolises of India, revealed that 76% had been sexually abused in childhood or adolescence. 82% of the abusers were either family members or persons known to the girl. Male cousins and uncles account for 84% of the abusers. 45% of the abuse took place between the ages of 4 and 12 years. All this when 60% of the mothers were housewives (RAHI, 1998). These chilling statistics about a 'privileged' class of women leave questions hanging about what may be happening in more deprived homes where perhaps less attention is paid to the girl child. However since a high premium is placed on virginity in Indian society, no one would want to publicly admit that they have been. At present, the Indian legal framework only recognises penile penetration of children under the law for 'Rape of Minors'. Other forms of sexual violation are not recognised.

Child marriage in India has been prevented by the law called Child Marriage Restraint Act (1978) that sets the minimum age at marriage for women at 18. Four states in India have the average age at 'effective' marriage either below or at 18, and all the rest (except Kerala) are at 19 or 20 (Registrar General of India, 1994). This actually means that the marriage takes place when the child is a minor, but the displacement to the house of the in-laws is counted as the age of 'effective marriage'. (While it may be argued that this protects the girl child from early sexual activity and pregnancy, it still means that marriage is taking place at an age when she is unable to give informed consent.) In fact 39% of girls in India between 15 to 19 are already married (NFHS, 1992-93). If we look at childbearing, 17% of total fertility is accounted for by births to women in the age group 15 to 19. Of the girls between 13-19 years who have been married, 58% are either mothers or pregnant.

Trafficking in girls and young women continues to flourish in the poverty-stricken zones of the country (86% of the sex workers are from UP, AP, Tamil Nadu, W.Bengal, Karnataka and Maharashtra) and there is also influx of girls sold into prostitution from Nepal and Bangladesh, who end up in the established red-light areas of metropolises. According to a Government of India survey done in 1991, there are around 70,000 to 100,000 girls and women engaged in prostitution. Younger virgins are especially in demand because of a popular belief that sex with a virgin can cure STDs. 15% of the sample surveyed (500) were below 15 years, and another 25% between 16 and 18. Also interesting is that 60% were from scheduled castes and tribes or backward classes. The current legal provision for this is called the Immoral Traffic (Prevention) Act, 1986, which does not seek to abolish prostitution or even punish the client who asks for commercial sex services, but certainly penalises a sex worker for soliciting in a public place. It does make procuring and brothel keeping an offence, but protection money is paid by brothel keepers to local 'toughs', police personnel and to politicians, creating an important source of income for the underworld. As far as the question of rehabilitation goes, girls and women rescued or arrested are the responsibility of protective homes, correction institutions or rehabilitation homes.

sanitation, and other basic needs. There has been a resurgence of infectious diseases which reflects this. A major dilemma is how to address women's reproductive health needs when the primary health infrastructure is in this appalling state, and budgets for health have been cut back (Sen, op cit.)

While 16% of the world's population lives in India, Indian women have very little say in global policies. The maternal mortality rate of Indian women is one of the highest in the world at 460 per 100,000 live births (WHO, 1991). Major causes include anaemia (18%), haemorrhage (16%), and unsafe abortions (12%) (Id). Maternal morbidity is projected to be 15 to 16 times higher than the number of maternal deaths. All this in a country which has had a programme for maternal and child health for a long time and where abortion has been legal from 1972, apart from the fact that contraceptive provision has started as early as 1952.

It becomes obvious that mere launching of appropriate-sounding programmes will not enable the millions of poor women in India to 'attain the highest standard of reproductive health'. In fact, given the current scenario, women's right to life itself is being violated, for they are unable to access life-saving healthcare / referral services. There are many reasons for this, one being state apathy, echoed in the indifference of government service providers. But there is also women's lack of power to make decisions concerning their reproductive health care, their lack of economic decision making, their inability to negotiate contraceptive use in a patriarchal society, and low literacy and mobility which prevent their access to information which could have protected their health and lives.

At present, the government has announced the 'Reproductive and Child Health (RCH) Programme', which is supposed to ensure a certain standard of reproductive health for women by providing services for safe motherhood and child survival, family planning, safe abortion, management and prevention of RTIs, STDs, and prevention of AIDS : all this for the ultimate goal of 'population stabilisation'! (MoHFW, 1997). Two years down the line, it is difficult to assess impact as there has not been very much progress in implementation, or even in service provider training, for that matter. The programme has possibilities, but in the absence of political will to address women's health needs, may not be able to bring about much change.

Violations of women's sexual and reproductive rights :

Looking at violations through the life-cycle approach, the practice of aborting female foetuses by determining the sex of the foetus through amniocentesis or ultrasound scanning reflects strong son preference in a highly patriarchal society. Although it is against the law, there are enough unscrupulous clinics flourishing throughout the country to ensure this 'service' to all who desire and can pay. Ironically, while people cannot access basic primary health care, and public health related information is unable to reach large sections of our society, this 'knowledge' has percolated deeply even into the rural areas. Doctors are profiting enormously from people's anxiety to know the sex of the foetus, and willingness to pay for late abortions. The same religion that extols the virtues and necessity of having sons, also preaches about the 'right to life' of the foetus (that is, against abortion). As such, a woman is always at fault: if she does not produce sons, she is pitied, scorned, even abandoned. She may be forced to

on the experiences of other women, and nothing is known regarding contra-indications.

One of the most detrimental factors in service provision has been the limited choice of methods available. Women are expected to be mute recipients of whatever the programme makes available to them. What is available is decided on the basis of programme efficacy, not on women's needs and preferences. Those who have no children can have the oral pill, those with one child may have the IUD inserted, and those who have two or more children are given no choice other than sterilisation. In fact, health facilities have been known to pressurise women seeking abortion into accepting sterilisation (Sundari Ravindran, 1993).

Women's health activists in India have been struggling against the government, donors and research institutions that seek to introduce unsafe and heavily provider-controlled contraceptives for Indian women, such as new hormonal technologies, transplants and even the anti-malarial, Quinacrine! At the same time, non-invasive user-controlled barrier contraceptives like the diaphragm or female condom are unavailable in the country. Whatever testing has been done has often violated the right to informed consent of the test subject, and has usually excluded women who are undernourished or anaemic, although this is the characteristic of most of the population of women in this country. Moreover, given the lack of adequate pre-examination and follow up by the service providers, any invasive provider-controlled method is unsuitable. Resistance movements over several years have finally prohibited the promotion of insufficiently tested contraceptives, but they are still being offered to women privately.

Despite the latest policies on the contraception programme, which declare that there will be no more method-specific targets imposed from above, and announce a 'community needs assessment approach' (GOI, MoHFW, 1998), there is no evidence on the ground to support the assertions of a 'client centred, quality of care, people driven programme' which goes beyond provision of mere contraceptive services to providing care for reproductive health as a whole. The mindset of programme managers and service providers has not been changed from their view that poor women are incapable of making rational reproductive decisions.

As such, while India supports RSR in providing free contraceptive and abortion services to women and men, the interest has always been 'population stabilisation' rather than the health of poor women, and as such the quality and purpose of these services remains questionable.

Healthcare services for safe pregnancy and childbirth.... the right to the highest standard of reproductive health :

Illness and death from reproduction related causes are particularly significant for women, but have been recognised only very recently in India. Estimates of the percentage of Disability Adjusted Life Years (DALYs) lost by Indian women due to reproduction related causes (maternity, cervical cancer, STDs, HIV) were as high as 10% in 1990. This does not include losses in the postnatal stage, or due to unsafe abortion, or anaemia, or malnutrition. Yet, public health and primary health services are also in a poor shape, with large numbers of people unable to access clean water,

Section Two

Issues And Debates In India

When we look at the situation regarding RSR in India, we find on the one hand some progressive legislation and policies, like

- the law permitting Abortion (something that women of many 'developed' countries are still struggling for),
- laws prohibiting sex pre-selection and female infanticide,
- provision of free contraceptive services and free abortion services,
- government programmes for safe motherhood and reproductive health (including RTIs, STD, HIV/ AIDS),
- shelter homes/ women's police cells/family counseling units/National Commission for Women,
- laws prohibiting child marriage and immoral trafficking
- and a secular state that does not persecute women on religious grounds

On the other hand, we also see several violations of reproductive and sexual rights , both by the state and society. This includes legislation against homosexuality, rape laws that are inadequate in dealing with the problem or ensuring justice, lacunae in dealing with domestic violence/ state-sponsored violence, and health policies that do not provide for safeguarding RSR. A discussion on the actual situation of the ground with respect to some of the crucial aspects of RSR is provided below.

Access to safe methods of family planning... information and means.. to make reproductive decisions free of coercion, discrimination and violence:

Right from the early beginnings of Family Planning programmes in the early 1950's, the main objective of population policy has been demographic control . The principal victims of this of this approach have been women's health and women's rights. Acts of commission such as the coercive use of sterilisation targets, incentives and disincentives, and the introduction of contraceptive technologies without adequate safeguards, and of omission such as ignoring the wide prevalence of RTIs and STDs, the high incidence of cervical cancer, and the risks of unsafe abortions, have been all too prevalent (Gita Sen, 1996).

Although a concern with reducing fertility has led to a national 'family planning programme' that has provided some women with access to contraceptives, the government does not adequately address the underlying socio-economic conditions within which its women citizens live, and as such, its policies possess the potential to aggravate the continued violations of Indian women's rights.

Despite the millions spent on information, education and communication (IEC), detailed information on the different contraceptive methods and their pros and cons is still unavailable to the majority of women. What they get instead is a lot of propaganda on why they should have fewer children. Knowledge of adverse effects is based solely

control her sexuality. The entire exercise is done with crude implements that can lead to uncontrolled bleeding, blood poisoning and death, apart from chronic urinary and reproductive tract infection, pelvic pain, immense difficulty in intercourse and childbirth, and even sterility.

Another harmful traditional practice involving girls is **child marriage**, prevalent in cultures that set a premium on virginity or have a well entrenched dowry system (a child would need less dowry). The child usually married to someone much older has to cope with the pain and trauma of early sexual activity, is unable to negotiate safe sex, and has to undergo pregnancy and childbirth before her body is ready, which could lead to prolonged labour, obstructed birth, tearing, and loss of control over the bladder or rectum.

Adolescents are also exposed to **sexual coercion, assault and rape**, and often faced with unwanted pregnancy, unsafe abortion or sexually transmitted infections. This stems from a popular belief that sex with a virgin can cure STDs. The stigma of rape can even drive girls to suicide, since the prevailing social attitude demands virginity before marriage. Another vicious practice involving young girls is burning the face with **acid** when she refuses to reciprocate 'declarations of love' from a man. This has been happening in South Asian countries for some time now. Then again, there is **trafficking** in girls from poor families who are often turned into commercial sex workers (CSWs), at an age when they cannot negotiate safe sex.

Women in the reproductive age group are faced with **domestic violence**, including physical abuse as well as emotional and psychological abuse. Women go through this because they have been conditioned to think that this is a part of marital relations, and also because they are dependent on their husbands in various ways. As a result they are unable to negotiate contraceptive use or safe sex, experience unwanted pregnancies and unsafe abortion, sometimes start premature labour because of being beaten during pregnancy, and also suffer from chronic abdominal pain, headaches, muscle pain apart from sleeping disorders.

Apart from this, women also face **rape and assault** outside the home, including rape in conflict situations involving caste, class, religion, ethnicity and so on. Women's bodies are used to 'teach men a lesson', since a woman's chastity is the 'honour' of her family, apart from a display of power over women themselves. Rape survivors face severe injuries, including reproductive tract injuries, unwanted pregnancy, infection from sexually transmitted diseases, as well as sexual dysfunction, depression and suicidal tendency.

articulated in ways that breach women's rights. Apart from this, some social institutions also violate women's RSR, like caste/ class/ religion based collectives, the police or armed forces, etc.

The UN Declaration on Violence Against Women (1992) understands Violence Against Women (VAW) as:

Any act of gender based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or private life. (Art. 1)

The international community also recognises the following forms of VAW:

- physical, sexual or psychological violence occurring in the family and in the community, including battering, sexual abuse of female children, dowry related violence, marital rape
- female genital mutilation and other traditional practices harmful to women
- nonspousal violence
- violence related to exploitation, sexual harassment and intimidation at work and in educational institutions
- forced pregnancy, forced abortion, and forced sterilisation
- trafficking in women and forced prostitution
- and violence perpetrated or condoned by the state

It cannot be denied that sexual violence is also faced by men, for child sexual abuse also extends to male children, and adult males are raped in situations of vulnerability such as the workplace, and educational or corrective institutions. But girls and women face systematic discrimination from entrenched power relations that perpetuate the almost universal subordination of females. This leaves them constantly and highly vulnerable to being harmed physically, sexually or psychologically by the men in their families and communities. Unfortunately, while gender-based violence has been established as a human rights concern, much less headway has been made in addressing VAW as a public health issue.

If we look at the forms of gender-based violence from a life-cycle perspective, and their consequences in terms of women's reproductive and sexual health, we find that women's rights are violated right from before birth until their post-menopausal years. A widely prevalent son- preference has led to **selective abortion of female foetuses and female infanticide**, especially in Asia and North Africa. Girls in the 1 - 4 age group have higher mortality rate than boys, reflecting neglect and denial of adequate nutrition and healthcare. **Child Sexual Abuse** is another widespread phenomenon that is rarely discussed, and little documented. One reason is that the abusers are frequently known to the child and her family. Studies confirm that apart from physical trauma, children suffer from long term psychological effects that lead to low self-esteem, depression, poor ability to delay or even negotiate safe sex, or enjoy intimate relationships.

Harmful traditional practices such as **female genital mutilation (FGM)** involves cutting off of the clitoris and the labia, sometimes even sewing the two sides of the vulva together, so as to prove to the marriage partner that the girl is a virgin, and

needs. The right to informed consent has also been violated, with researchers and service providers conducting invasive procedures on women's bodies without bothering to ask.

Further, women's health advocates have viewed RSR in the context of present gender disparities : according to them, ' a definition of RR must include women's economic, political, legal, educational, and general health rights. It is only when these rights are recognised as having a focal role in their reproductive choices that population and demographic patterns can be properly understood...' (Shirkat Gah, 1994). This is because one of the key obstacles to women exercising rights over their own bodies is their disempowered status in family and community decision making processes

RSR also stem from the philosophy and struggle of the feminist movement. As Rosalind Petchesky said in a pre-Cairo women's conference :

"Four basic ethical principles lie at the heart of RSR: bodily integrity, personhood, equality and diversity. All four have both negative and positive applications - that is, they involve both protection against coercion and abuse, whether by state officials, medical personnel, kin, or sexual partners; as well as the fulfillment of basic needs.....

Bodily integrity involves people's rights not only to be free from physical abuse, coercion or violence but also to be enabled to enjoy their body's full potential for health, procreation and (safe) sexual pleasure.

Personhood ...refers to women's right to be treated as principal actors and decision makers in matters of reproduction and sexuality; as subjects not objects, of medical, social and family planning policies.

Reproductive and sexual equality - both between women and men and among women, has to do not only with prohibiting discrimination... but also with providing social justice and the conditions of development..

Finally, *the diversity principle*, requires respecting the differing values, needs and priorities among women - based on culture, ethnicity , religion, sexual orientation, and nationality - but as women themselves, not male kin, politicians, or religious leaders who define those values, needs and priorities.(Petchesky, 1994)

Women's health advocates assert that 'a right is no right if those for whom it is meant do not know of its existence, and if services are not provided to ensure its enjoyment. It is the responsibility of governments and organisations to ensure that individuals and couples are given access to both information and services. In addition to this, societies should make all effort to free their citizens of practices, taboos and constraints which deny them other reproductive rights and freedoms'. When governments seek to deal with some of the most private and intimate aspects of people's lives by not ensuring informed consent and by providing women with inadequate and inaccessible services, they are infringing women's reproductive rights.

Violations of Reproductive and Sexual Rights

An exclusive focus on culpability of the state for inadequate reproductive health policies may deflect attention from societal responsibility for pervasive violations of women's RSR. Yet perhaps the most consistent violators of women's rights can be individuals and family members. There are also deep-rooted cultural practices that are

Sexual rights further includes the right to experience a pleasurable sexuality, which is essential in itself and is a fundamental vehicle of communication and love between people. It also includes the right to liberty and autonomy in the responsible exercise of sexuality (HERA, 1998)

Perspectives and Struggles of the Women's Health Movement

The women's health movement has had to struggle against several fronts. On the one hand were the demographers and planners, who felt the goal of reducing population growth justified coercive, and sometimes downright dangerous means. On the other hand were religious fundamentalists, who opposed contraception, abortion, sex education, and promote practices that restrict women's education and mobility. Then there were countries that brutally sought to restrict women's sexuality through customs like Female Genital Mutilation. Besides these were the usual biases: against single women, against including men's responsibility, against providing services and information to adolescents, and so on. The challenge was to negotiate differences about morality; of separating sexual behaviour from reproduction; and 'freeing' sexual activity to the extent of 'promiscuity'. Then there was also the school of thought which held that given widespread poverty and lack of the very basic amenities, it was a 'western' luxury to talk of reproductive rights!

Stated simply, reproductive rights provide women with the freedom to control their bodies and obtain needed health services. But reproductive health occupies the crux of women's subordination and is really a 'political question of choices and the right to choose', rather than a medical question of providing care for infections of the reproductive tract or the urinary tract or through sexual transmission. The key challenge in the whole quest for reproductive rights is to address issues of power and gender relations.

Women's health advocates have viewed RSR as 'constellations of legal and ethical principles that relate to an individual woman's ability to control what happens to her body and her person by protecting and respecting her ability to make decisions about her reproduction and sexuality (Freedman, 1995). Yet respect for these rights has profound consequences. All women would then maximise their chances of enjoying good health, accessing quality reproductive health care, entering only into consensual sexual relationships and deciding the number and spacing of their children by using safe and acceptable contraception. But the right to control reproduction remains elusive for most women. Their bodies are often pawns in the struggles among individuals, families, religions and states. Women continue struggling to reclaim their bodies, given the context of denial of some of the basic rights: to liberty, to security, and to decide whether, when and with whom to found a family.

Moreover, when we talk of the freedom to access services, such services must be provided in a context that respects women's moral agency and that treats women as principal decision makers in matters of reproduction and sexuality. Unfortunately, the opposite has often been the case, and women have also been denied the right to access contraceptive services or other healthcare, the right to quality of care, (including counseling), apart from not being provided with appropriate healthcare for women's

reproductive and sexual health and rights, and stressed the need to empower women while increasing men's responsibility.

Some definitions of Reproductive and Sexual Rights

A definition of RSR has been comprehensively set out in the ICPD Programme of Action (PoA) which draws from the explanation about Reproductive and Sexual Health (RH, SH):

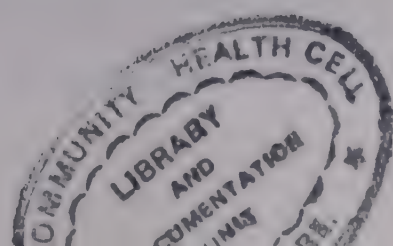
(Art. 7.2) Reproductive Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive Health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice,..... and the right of access to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth..... Reproductive health also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases.

(Art. 7.3) RR embrace certain human rights that are already recognised..... These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion, and violence,..... The promotion of the responsible exercise of these rights for all people should be the fundamental basis for ... policies and programmes in the area of RH.....

(Para 7.37) Human sexuality and gender relations are closely interrelated and together affect the ability of men and women to achieve and maintain sexual health and manage their sexual lives. Equal relationships between women and men in matters of sexual relationships and reproduction, including full respect for the integrity of the human body, require mutual respect and willingness to accept responsibility for the consequences of sexual behaviour.

Sexual Rights(SR) were further described in the Platform for Action of the Fourth World Conference on Women (1995), which said:

(Para #96) The human rights of women include their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. (After this, is the ICPD language from Para. 7.37 again, with the significant inclusion of the word 'consent').



Section One

Understanding Reproductive And Sexual Rights

The History of RSR

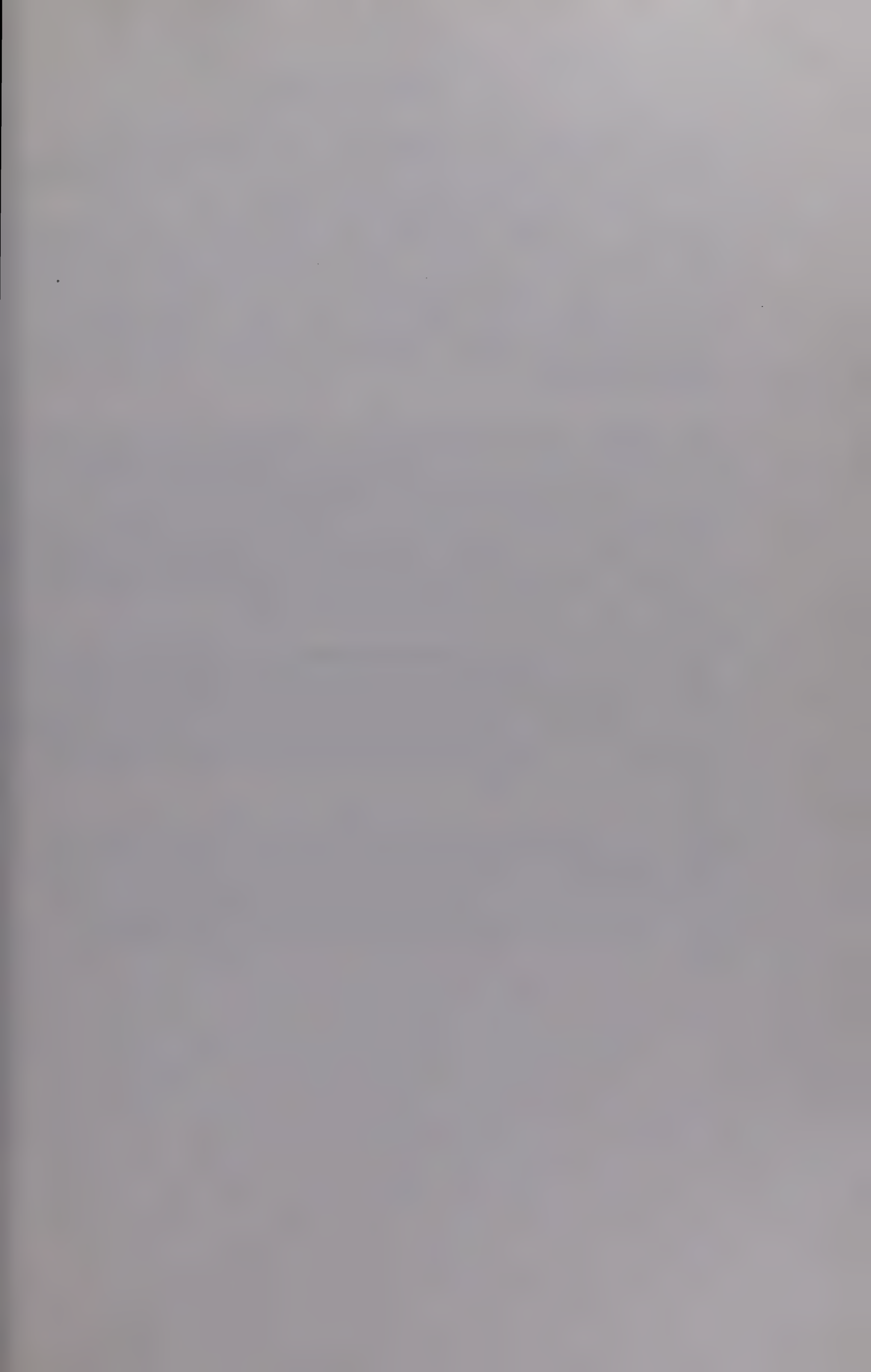
The first statement of rights with regard to reproduction was at the UN organised International Human Rights Conference at Teheran in 1968 which said that 'parents have a basic human right to decide *freely and responsibly* on the number and spacing of their children and a right to adequate education and information in this respect'. The catchword here is '*responsibly*', which left ample room for international organisations and governments to carry out coercive measures with the excuse that citizens had not been 'responsible'! This was very much on the agenda, since the dominant western thinking in those days was influenced by Paul Ehrlich's *The Population Bomb*, which presented a grim picture of the global devastation resulting from unchecked population growth (especially in Third World countries).

In 1974, at the World Population Conference at Bucharest, there was a new element introduced into the debate by developing countries, saying that development affected population, rather than the other way around. The Plan of Action adopted there once again reaffirmed the earlier language with some changes: the word 'parents' was changed to 'all couples and individuals', and to 'education and information' was added the word 'means'. Moreover, the element of 'responsibility' was defined in some more detail.

On the other hand, by 1975, the international women's health movement had articulated its philosophy that every woman must have the right of control over her body, her sexuality and her reproductive life. This was in opposition to the movement to control population growth (especially through focussing on women) in the Third World. At the International Women's Year Conference in Mexico City, the earlier language of the right to reproductive choice was firmly grounded on a notion of bodily integrity and control: "The human body, whether that of a woman or a man, is inviolable and respect for it is a fundamental element of human dignity and freedom"(Art.11, UN, 1976). The Convention on the Elimination of all forms of Discrimination Against Women (CEDAW) codified the right of reproductive choice "on the basis of equality between men and women"(UN,1979).

By 1984, however, a strong Anti- Abortion movement had taken root, especially in the US, and was calling itself the 'right to life' movement, although women's health advocates saw it as 'anti-choice'. This changed the attitude and funding of the US Government towards population growth. Nonetheless, the recommendations of the 1984 International Population Conference at Mexico City urged that "governments can do more to assist people in making their reproductive decisions in a responsible way"(UN,1984).

This was the context of the Cairo ICPD in 1994. Given the inequities between countries, different view on human rights, and strong pressure from the women's health movement, the conference was yet able to negotiate a document that recognised the central role of gender relations in women's health and rights, defined



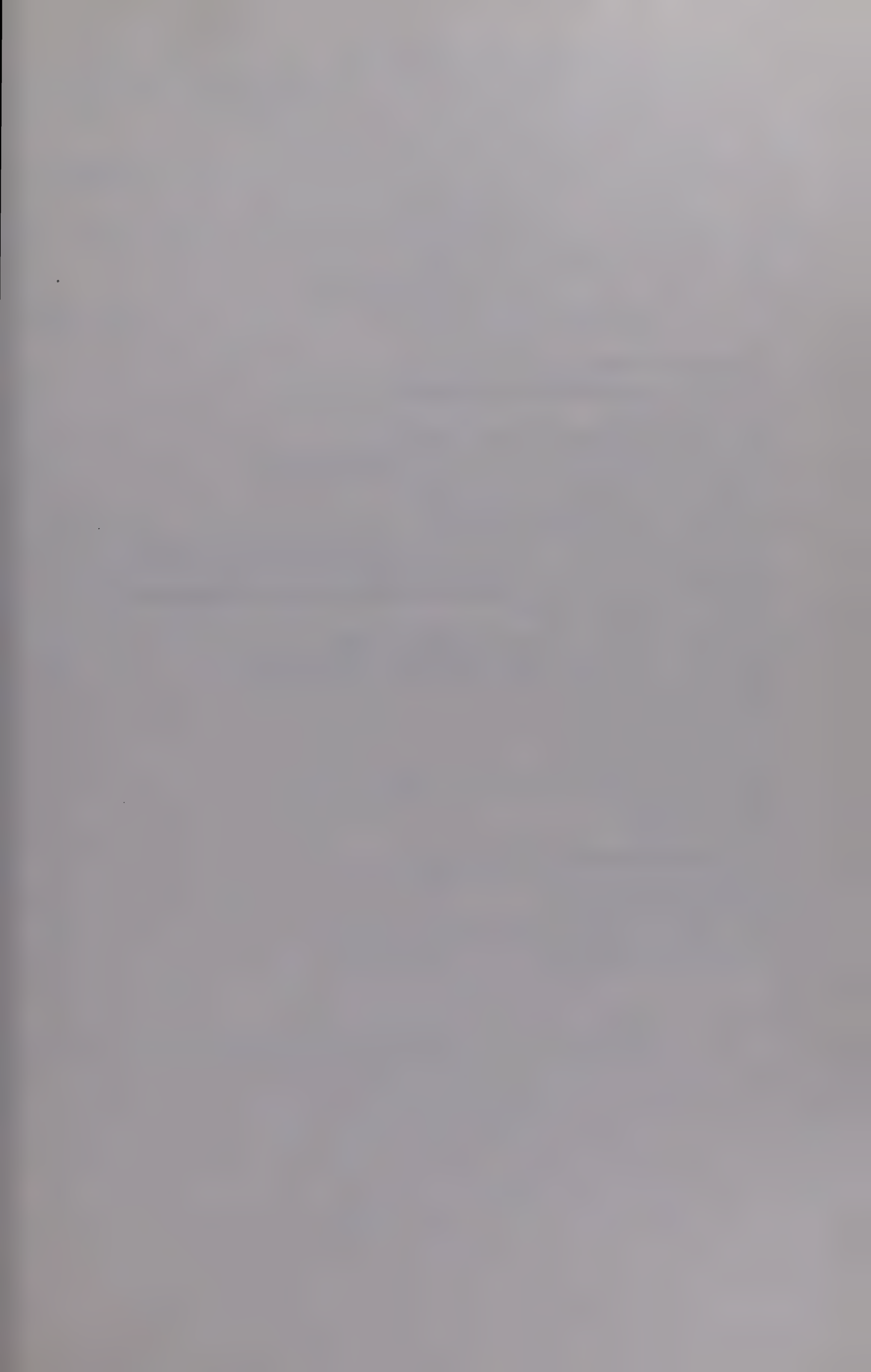
INTRODUCTION

The term Reproductive and Sexual Rights (RSR) gained popularity after the International Conference on Population and Development (ICPD, 1994), although 'rights' language with regard to reproduction had already been used all the way back in 1968 at the International Human Rights Conference in Teheran. In order to understand the term Reproductive and Sexual Rights, we need to explore the meaning of the expression '*Rights*'. It conveys a sense of entitlement, although it cannot always be taken for granted. This particularly so in the case of women's rights, which need to be constantly defined and even struggled for. The process of defining rights more often than not stems from a perception of ongoing injustice. Yet, even when rights are encoded, they cannot be assumed as a prerogative, and violations are more often the rule than the exception.

When we reflect on the exercise of rights, some questions arise, such as: do people have rights before they are aware of them? Or is it imperative that rights have to be known and exercised if they are to exist? Further, can rights be 'given'? Or is it always necessary for those deprived to struggle for them? Does society have any responsibility in this matter? Moreover, can we understand rights if there have been no 'wrongs'? That is, must violations always precede acknowledgements of rights? These are some of the fundamental questions that have to be answered if we are to work on any sort of rights, including reproductive and sexual rights.

Sexual and Reproductive Rights have been encoded in several international documents, some of which are legally binding and some more in the nature of an agreement between states. However, the ICPD document was an explicit statement that brought the term Reproductive and Sexual Rights into popular parlance. It marked a watershed through which the women's health and rights movement was able to generate great impetus for its advocacy work.

This booklet provides some definitions and the history of reproductive and sexual rights. It also highlights their importance and deals with the aspect of their violation. Further, this booklet also raises some issues and debates about Reproductive and Sexual Rights in India, and suggests programmatic implications. At the end is a resource section, giving a reading lists and some other information which may be useful.

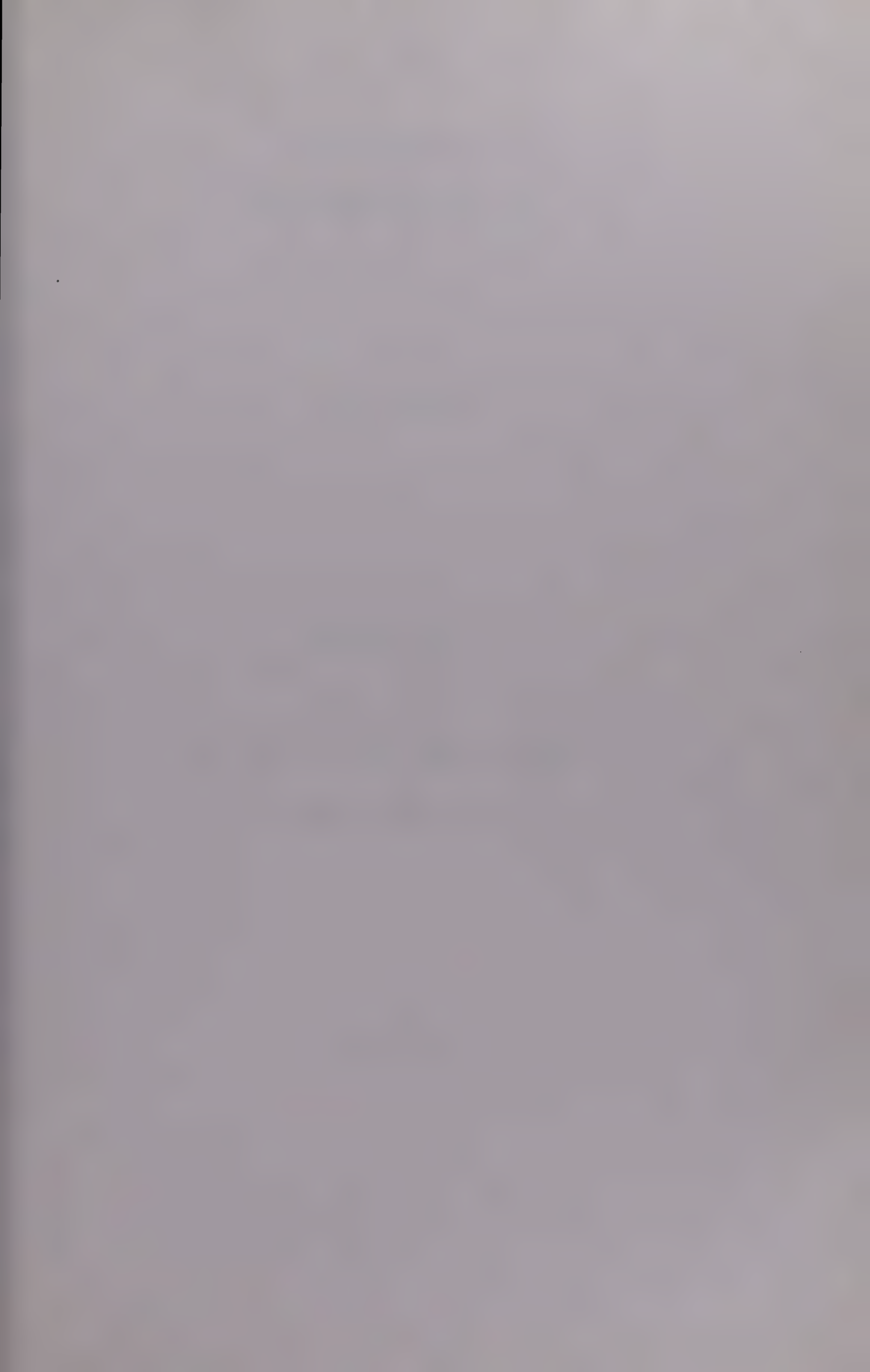


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UNDERSTANDING
REPRODUCTIVE HEALTH

A Resource Pack

Booklet - Four

POPULATION AND DEMOGRAPHY

Understanding numbers

SAHAYOG



INTRODUCTION

The *teeming millions*, *the population bomb*, *the serious overpopulation*, *the problem with population* and similar expressions have now become very commonplace in the media, at meetings and seminars and even during casual discussions over a cup of tea. Sometimes this discussion is about poverty, sometimes about the environment or even when there is a traffic jam or when railway reservations become difficult to obtain. When these words and expressions are being used we are unconsciously referring to some theories and arguments put forward by some thinkers. And serious thinking about the issue of population started some two hundred years ago. Much of the general discussion on population (especially with regard to over population) is based on an alarmist view where population is seen as a threat to middle class survival.

While population is projected as a major problem in most spheres, there is an equally strong view which does not do so. The only difference is that this point of view is not so aggressively promoted and thus has not become popular. The logic here is that people are a resource and the poor opt for larger families as a part of their survival strategies. There is also a big debate about the role and position of women in the entire population related discussions, policies and programmes. For the not so well informed person the entire issue becomes further clouded when statistics and studies are quoted or different technical terms used.

In this section we will try to acquaint the reader with some of the debates, issues and terminology associated with population and demography. An attempt will also be made to contextualise the issue of population and demography in the present social reality in the country. A separate section - Reproductive Health- Policy and Advocacy will deal with the different population related policies and how they evolved over time.

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Section One

Understanding Demography And Population

Definitions and Concepts

Demography and Population Studies - The study of human population is known by the two terms - demography and population studies. In many cases these two terms are used interchangeably; but some scholars also try to distinguish between the two. Broadly speaking population studies is concerned with understanding what are the kinds of changes taking place in the size and nature of human populations. It is also concerned with why these changes are taking place. The distinction that is sometimes made between the is usually along these lines- demography is said to refer to the hard core analysis of numbers while population studies looks at the behavioural aspects affecting the reproductive behaviour of people. Fertility, mortality and migration are the three basic aspects which considered influence the population of a particular place.

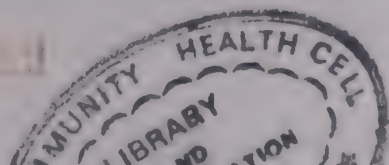
Mortality Measures - Information about mortality or how deaths take place within a community is very important from the point of view of estimating the healthiness of a community and understanding how it will grow. If the rate at which people die is more than the rate at which births occur the number of people (population) will decrease and the reverse will occur if the death rate is lower than the birth rate. Some of the common measures of measuring mortality in a community are given below.

Crude Death Rate (CDR) - This is a widely used index of mortality, but it is not supposed to be a very sensitive one. It is calculated by dividing the total number of deaths in a community from all causes by the mid year population of the community and expressing the result in terms of 1000 population. Disease specific and age specific death rates can be calculated in a similar way by modifying the numerator and the denominator in the equation. By and large developed nations tend to have lower death rates than developing nations but the gap has been rapidly closing over the last few decades.

Infant Mortality Rate (IMR)- The term infants refers to children under the age of one year, and they are supposed to be specially vulnerable to different diseases and consequently to death. This measure is supposed to be a more sensitive reflection of the health status and well-being of a community. In actual terms it is calculated as the ratio of the total number of children dying under the age of one year to the total number of live births occurring in the year expressed per thousand live births. The difference in IMR between the developed and developing nations can be to the order of ten times. Developing nations having an IMR in the region of 5-10 per 1000 live births and developed nations about 100.

Table 1 : IMR of selected Indian states
(for a five year period preceeding 1992-92, NFHS – 1992-93)

State	Infant Mortality Rate
Kerala	23.8
Maharashtra	50.5



Punjab	53.7
Tamil Nadu	67.7
Uttar Pradesh	99.9
Orissa	112.1

Maternal Mortality Rate (MMR) - This is a very significant indicator of the state of health services and well being of women in a society. It is measured as a ratio of the total number of deaths in women which are attributable to pregnancy and childbirth, divided by the total number of live-births in a community expressed in 100,000. In practical terms it is difficult to indicate deaths which are remotely attributable to childbirth so all maternal deaths in pregnancy and up to 42 days after childbirth are considered for this purpose. Unfortunately accurate information about maternal mortality is often not available in many developing societies. The difference in MMR between developed and developing nations tends to be the highest among the three indicators discussed.

Table-2 : Mortality and fertility figures of selected Indian states (SRS)

State	Crude Birth Rate (1996)	Crude Death Rate
Kerala	17.8	6.2
Maharashtra	23.2	7.4
Punjab	23.5	7.5
Uttar Pradesh	34	10.2

Measuring Fertility - Fertility refers to the actual births that women undergo. Different fertility measures are used to measure the total number of births that take place either in a community or at the level of an individual woman. Fertility behaviour has been one of the most widely studied aspects in the field of population studies. Some of the commonly used measures of fertility are described below.

Crude Birth Rate (CBR)- This the simplest measure of fertility and is calculated as the ratio of the total number of live births in a community divided by the total mid-year population in a particular year and expressed per thousand population. It is not considered a very sensitive measure of actual fertility because it is calculated including a large group which do not have the ability to give birth.

General Fertility Rate (GFR)- This is a more accurate measure of fertility in the community and the denominator is restricted to women in the age bracket 15-44, because that is the reproductive age group. Even more specific rates refer to women in different age brackets.

Total Fertility Rate (TFR)- This is a slightly different indicator because here the rate does not refer to a community as a whole but to individual women. This rate is very commonly used and refers to the total number of childbirths an individual woman undergoes in her entire reproductive life. The calculations involved are reasonably

complex, but it is a useful measure to compare the fertility of individual women across different periods of time or across different areas.

Table-3 : Comparison of TFR over time and place (SRS)

State	1992 (U)	1992 (R)	1993(U)	1993(R)	1994(U)	1994(R)
Kerala	1.7	1.7	1.7	1.7	1.8	1.7
Maharashtra	2.3	3.3	2.6	3.2	2.6	3.2
Punjab	2.7	3.2	2.6	3.2	2.6	3.0
U.P:	3.8	5.6	4.5	5.4	4.0	5.4

Net Reproductive Rate (NRR)- This rate refers to the potential reproductivity of a population by calculating the average number of daughters born to mothers. The assumption being that if there are more daughters born to the succeeding generation the overall population is bound to increase- because there will be more child-bearers in the future. When the NRR is less than one then the population can be expected to decrease as there will be lesser numbers of child-bearers in the future. An NRR of 1 is referred to as Replacement Level Fertility because at this rate total number of current childbearers/mothers are being replaced by an equal number of future childbearers/daughters. India has a goal of NRR 1 by 2000 .

Table-4: Desired Demographic Goals

Goal	By 2000 (6 Plan estimates)	By 2006-7 (8th Plan estimates)	Actual Situation- 1991.
NRR	1	1	
CBR	21	21.7	29.5
CDR	9	7.4	9.8
IMR	60	48	80
LEB	64	66.1(M)67.1(F)	60

Migration- This is the third important determinant of the total population of the place after births and deaths- and so demographic study is also concerned with how and why people move from one place to another. Simply stated migration refers to the movement of people from one place to another. The UN has added that the movement or change in residence should be for a minimum period of one year and that some administrative boundary should have been crossed. People usually migrate after marrying (especially women) or in the search of livelihood. Migration is either internal or international. The internal migrant is referred to as an in-migrant or an out-migrant and the person who crosses international borders an immigrant or emigrant depending on whether s/he is coming in or going out. In many cases migration has a significant effect on the situation of both the place the person leaves or goes to.

Demographic Transition- This is a theory which tries to explain how the population of a particular region changes over a period of time with advances in the economic and social conditions. According to this theory early agrarian life was characterised by high rates of birth and death with no consequent increase in the population (high stationary phase). This was followed by the early expanding phase where due to advances in the

field of health services and economic situation the death rates decline fast but the birth rates were still high. In the third phase the birth rates too declined and the growth rates started declining- late expanding phase. In the fourth or low stationery phase birth rates and death rates again match each other but both the figures are very low. In the fifth and final phase the birth rates reduce even further while death rates have reached their lowest possible level and are more than the birth rate. Here the population starts declining. This theory is based on the historical observations in developed countries. Many countries today are not following this typical model which correlated development with population growth.

Sex Ratio- This is the ratio of the population of men to women in a country or region. It is expressed the number of women for every thousand men. An inverse sex ratio refers to the situation where the number of women for thousand men is less than one thousand. This inverse sex ratio usually denotes a lower social position of women. In India the sex ratio has always been inverse and this is also true of China and other South Asian countries. In other, particularly non- Asian countries the number of women is usually more. The sex ratio in India declining in every census except during 1981. At present the sex ratio in India stands at 927 (1991).

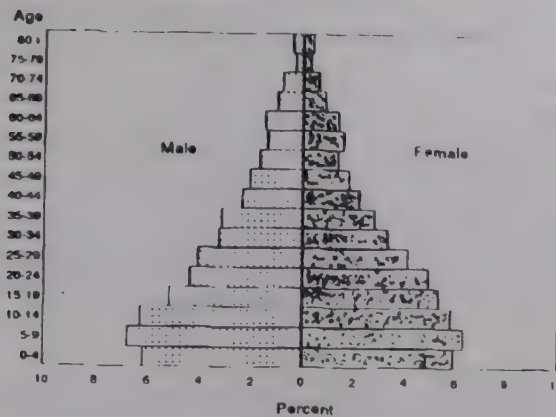
Table: Sex Ratio of Selected Indian States (Census-1991)

State	Sex Ratio
Kerala	1036
Maharashtra	934
Punjab	882
UttarPradesh	879
Orissa	971

Population Pyramid (Age -Sex structure)- When the population of a particular region is arranged graphically according to age-groups and sex we get a graph which resembles a pyramid. This population pyramid provides a lot information about the composition of a particular society and its situation. In a typically developed nation, where the birth rates have declined a considerably long time ago and the life expectancy of the population is quite high the population pyramid is in the shape of a column while in a different country where birth rates are high and life expectancy is lower the pyramid is shorter and more acute.

It is clear from the Indian pyramid that the Indian population is much younger , and about 40% of India's population is usually under the age of 15 and this has been steady for a long time. On the other hand the proportion of population above the age of 60 is increasing, due to decrease in mortality. The **dependency ratio** refers to the proportion of under 15s and over 60s to the population between 15 and 59. The dependency ratio in India is about 75%.

Population Pyramid of India



Population Pyramid of India (NHFS -1992-93)

Expectancy of Life - This is a measure of how many years a person is expected to survive in the prevalent situation. This measure can be calculated at any particular age though the common practice is to refer to life expectancy at birth. In some situations life expectancy at one year of age is also considered and this figure is usually more than the Life Expectancy at birth because the risks of dying in the first year are high. India has made dramatic progress in Life expectancy at birth and from a lowly figure of about 31 in 1951 it has increase to around 60 years in 1991. Life expectancy at birth of women is usually higher than that of men. In India this was not the case till very recently.

Growth Rate- This is a figure which is the nightmare of Indian planners and demographers. It refers to the overall growth of the population and is calculated either annually or every ten years. The decadal growth rate in India is over 20% with the north Indian states of U.P., Bihar, Madhya Pradesh having a decadal growth rate of about 25 % percent during 1981-91 . South Indian States like Kerala and Tamil Nadu on the other hand had decadal growth rates of about 14% in the same period. Annual growth rates are less than 10% of decadal growth rates because the growth is cumulative. Annual growth rate in our county is around 2%.

Population Projection - This is an estimation or forecasting of the population of a particular region at some point in the future. In order to make this projection complex mathematical calculations are made utilising the age-sex distribution, mortality, fertility and migration figures or the region. Different scholars use different assumptions about growth and it is possible to come up with different figures using different methods. Population projection is an important tool for planning and policy formulation.

Sources of Demographic Information

Census - The enumeration of the entire population of a country or a region at a particular time is known as a census. Usually census is conducted at definite intervals which in India is after every ten year. During a census every individual is separately recorded and every effort is made to cover the entire territory. Ideally the whole effort should be done on one single day. Census is usually the primary source of basic population data at the national or state level. This data is required for various administrative, planning and research purposes

Census in India- The first comprehensive census in India took place in 1881 and since then has taken place after every ten years. The next census is due in the year 2001. The census is the responsibility of the Union Ministry of Home Affairs. Before 1951 a temporary census organisation would be set up for every census but since then a permanent office of the Registrar General has been set up. At the state level there are Directorates of Census Operations. The Registrar General is responsible for census, registration of birth and deaths, and for conducting other relevant surveys. The census is conducted in accordance with the Census Act of India (1948).

How a census is conducted - Conducting a census in India is very large operation because of the size of the population and the extent of the country. A large number of enumerators are used for the purpose which includes primary school teachers, village level officials and patwaris, clerks and government office employees. The total number of persons involved during the census of 1991 was 1.7 million. The first activity of the census is the house-listing which is done before the actual headcount starts. Each house is given a unique number and information about the house including its type, purpose, size, number of inhabitants and so on are recorded. During last census the availability of toilet was also included in the information gathered. This is followed by the enumeration process which ideally should take place on a single day. There are two types of enumeration - *de facto* - where all persons who spent the night in a certain house on the particular day are counted there or *de jure* where all persons normally residing in a particular house are recorded together. In India the *de jure* method has been in use since 1941. The Individual Slip is core of the Indian census and in 1991 information on 23 different items were recorded under four broad heads. These are Demographic and Social, Educational, Migration and Economic. The actual number and items under which information is obtained has varied from census to census.

How Census data may be obtained - Information gathered during the enumeration process is compiled in to summaries which are prepared district-wise. Primary census data is available up to the village level while information about the economic and migration status is available in tables up to the tehsil level. All this information and information about general background of the district is published in the District Census Handbooks since 1951. Unfortunately it takes quite some time after the census for these to be released, but fortunately the information is now available in diskettes from the office of the Registrar General or from the State Directorates. One has to pay a small fee which depends upon the amount of space the information required occupies in terms of the number of diskettes. There is a differential rate for information required for commercial or non-profit purposes.

Registration of Vital Events - Births, deaths, marriages and divorce are called vital events in demographic parlance. According to the Registration of Births and Deaths Act (1969) it is compulsory for all births and deaths in the country to be recorded. In urban areas this is conducted by the Municipalities while in rural areas the responsibilities has been given to gram pradhans. Based on these records the Registrar General of India compiles the Vital Statistics of India. Unfortunately the recording procedures are still not complete and these data can be inaccurate.

SRS - Sample surveys are a method of collecting information in which instead of obtaining information from the whole population, it is obtained from a representative set and the conclusions applied to the whole group. The Sample Registration System or SRS is a survey which has been ongoing since 1964-65 and now covers the whole country. Under the SRS continuous enumeration of vital events as they take place, is done in a set of sample villages and a survey is also done every six months in the same sample. The results from the two different sources are matched and published in the SRS Reports (Annual) and SRS Bulletin (six-monthly) by the Office of the Registrar General.

National Family Health Survey (NFHS) - This is a nationwide survey which was first conducted in 1992-93 with the objective of collecting information about fertility, knowledge and practice of Family Planning, Maternal and Child Health, infant and child mortality and their reasons and determinants. Information has been compiled into National and State level reports which are available with International Institute of Population Sciences and State level Population Research Centres. The next round of the NFHS is due in 1999. Unlike other population related surveys this survey is coordinated by the IIPS and is sponsored by the Union Ministry of Health and Family Welfare. Information available in the NFHS reports include statistics on fertility, practise of Family Planning, utilisation of antenatal services, immunisation of children, breast feeding and infant feeding practises, infant and child mortality. NFHS data is available as posters, summary reports, state wise detailed reports and a country report.

Section Two

Debates and Discussions

Population is a Problem

This argument has roots in what is commonly called Malthusian thinking. Thomas Robert Malthus was an English clergyman and college professor. In 1798 he wrote an essay in which he proposed that the growth of human population will outstrip the growth in food production, and thus population growth needs to be checked. He argued that while food production increases in arithmetic progression (1,2,3,4...), human population increases in geometric progression (1,2,4,8...). In this situation there will not be food for all. The checks that he had proposed, being a clergyman were mostly restricted to moral restraint.

While Malthus' original fear that food production will not be able to keep up with the growth of human numbers has been unfounded due to rapid progresses in agricultural technology, an extension of this logic is still being offered by a group of thinkers who are now called neo-Malthusian. These writers have been looking at the natural resources of the world as a whole and feel that the earth's natural resources will not be able to support the growth of population and call for public policies to restrict the growth of population. National Family planning policies and programmes that different countries have adopted were a result of this logic.

People are a Resource

This stream of thought is diametrically opposed to the Malthusian arguments discussed above. Marx and Engels had argued against Malthus that there can be no single law of population increase and different modes of production tended to encourage different situations. They felt that capitalist societies would encourage large number of poor people so that wages would be forced down. We can see a similar situation today where countries which provide most international aid for population control also shift their production bases to the same countries because the labor rates are the cheapest there.

Many studies have also shown that the poor in different countries see greater economic sense in the number of persons in their own family. Children provide solid economic support either by taking care of household chores, thereby freeing adults to seek other modes of income generation, or they even contribute labour in many sectors- witness the carpet, bangle and firework industry in different parts of India.

Malthus had argued that such people who do not contribute as much to society as they produced were a primary reason for the inadequacy of food supply. Marx and Engels had argued that each individual always produces more food than she or he can consume. If we follow this logic then people are a resource, and poor people's behaviour all around the globe tends to prove this. But the problem of inadequate resources still persists and we will examine this in the next argument.

Population and Natural Resources

This is a very strong argument nowadays and has the sanction of environmentalists around the globe. In a way it is an extension of Malthusian thinking and has been receiving tremendous attention since Paul Ehrlich's book "The Population Bomb" was published. In this thinking the argument of food supply is extended to include all natural resources and the argument correctly concludes that at today's accelerated rates of consumption, there is very little going to be left of the earth's natural resources very soon. But what needs to be carefully thought out is that who consumes all the resources. It has been conclusively shown with data from all sectors that the consumption of natural resources is mainly a product of the extravagant Northern countries (the developed countries) and not the meager needs of the poorest nations. The whole problem is more a question of distributive justice rather than that of larger numbers of people *per se*. But even after such information has been available for a long time now, these northern countries are extremely wary of cutting down on their own consumption levels.

Turning a somewhat blind eye to their own consumption behaviour these countries and thinkers have been involved in aggressively promoting Family Planning programmes in the poorer nations of the world. The World Environment Conference at Rio in 1992 was supposed to be one platform where such issues were to be debated by all countries but the final outcome has left much to be desired, in terms of commitments to reducing levels of consumption in these countries.

Family Planning or Development?

It is often argued that the larger the density of population in a country the greater is its population problem. It is also argued that the greater the density of people, the greater the strain on the carrying capacity of the land. But then urban conglomerations have the greatest density of people and they are also supposed to be the most developed. It has now been accepted that just the reduction of numbers is not the goal but the development of people. Family planning is supposed to assist in achieving this goal. There is a great degree of disagreement as to what development implies, and we will touch upon at some of these disagreements in the next debate. Even then there is some agreement that life expectancy, mortality rates, literacy rates are some of the essential indicators of development. And examination of figures across countries show that there are many countries where the density of population is large but these are better 'developed' than others with much less density. Thus we need to look beyond absolute numbers in terms of density to family sizes and fertility rates.

It is argued by some people that once social development (even in terms of the some indicators mentioned above) is promoted , people tend to regulate family sizes on their own . It is also true that the western world achieved population stabilisation much before contraceptives were either available or aggressively promoted. Thus the state should try to fulfil its obligations to health services (prolong life and reduce death) and education, especially for women and the population problem will take care of itself. It is interesting to note that the leader of the Indian delegation to the 1974 conference on

Population in Bucharest had argued in a similar vein and the country started its aggressive Family Planning programs very soon thereafter.

Social Development and Population

Decline in population has long been held as major product of economic development, but increasing evidence gathered through the years is now challenging this opinion. According to evidences gathered in Kerala (a favourite subject of study of demographers) and elsewhere it has been proposed that economic development is not a necessary condition for population decline , but on the other hand the socio-cultural milieu, education of women, position and status of women, increase in the quality of life across age-groups, infrastructural facilities, efficient health services including contraceptive services, high cost of living etc are more essential factors in reducing the desired number of children in families.

Since such a large number of factors affect the number of children in a family, the study of population and fertility is increasingly becoming a multidisciplinary subject with people with various interests becoming involved. These include people from the disciplines economics, sociology, psychology, geography, public health, anthropology, women's studies and of course from mathematics and statistics. Social scientists, program managers and even activists from different fields who are interested in the socio-economic-political development of people (especially the poor) have often got to place their work in terms of the impact it makes in terms of the numbers of people or the quality of their lives . In such occasions a knowledge of demography comes in handy.

Population and Poverty

In conventional development discourses population and poverty are seen as not only interrelated but often as cause and effect. In this vision of things the only way to economic growth is to control populations. And most population programs around the world have started with this belief. But right from the time of Malthus it has been the numbers of the poor that have mattered- it was never a problem of overpopulation of the rich. Unfortunately this form of thinking makes the mistake of recognising the symptom for the cause. That poverty is not the cause for overpopulation has to be clearly recognised. In fact there are some countries which have successful population control programs and continue to be very poor. In order to understand the reasons behind the overpopulation of the poor one will have to understand why people are poor and for this one will have to examine the structure of power- political power, economic power, social power. One will also have to address the different structures that keep these systems of power alive.

Population Control and Women

Population Control has been a major area of concern for women's rights activists around the globe. In fact much of the new understanding on population issues and changes in population policies have been due to the concerted efforts of feminists, scholars and activists. Some of the major debates and advocacy struggles will be highlighted in the section on Reproductive Health- Policy and Advocacy.

Population Control affects the lives of women very deeply because women are seen as the main party in procreation or adding to population. Thus almost all population control strategies have been focussed on women as targets of contraceptives- pills, injections, sterilisation operations and so on. Women have also been long perceived as soft targets and this has often led to very coercive situations in different parts of the world. This attention that women have received as potential or actual mothers is in sharp contrast to the attention that women's health has received in different countries in the world. This anomaly has led to women's health activists around the globe to take very strong, and justified positions on population control. It has been argued by many experts that women's education, social position, economic conditions, decision making abilities are far better predictors of the number of children she will opt for than limited population control regimes focussing on temporary and permanent contraceptive methods.

According to some authorities there are two main stands that women usually take on the subject of population control. These can be summarised as follows-

The *radical* viewpoint rejects all population control policies as being anti-people and being promoted by western vested interests because they focus on the population of poor countries. The proponents of this point of view reject the government's role in regulating the size of families, because it has often led to coercion and violence against women, and stress on the Governments role in welfare of people and of women. The second point of view which may be called *progressive* calls for a feminist population policy which is more broadbased and focusses on women's health, empowerment and rights. It calls for framing of holistic population policies which include issues like abortion, infertility, safe motherhood, free and informed choice in the number and spacing of children and access to contraceptives and so on. This progressive view point is the dominant voice in the international women's health movement today.

Population Control and Family Planning

Very often these two words are considered synonymous. The roots of this kind of thinking perhaps lie in the belief that family planning is the best way for population control. India's Family Planning programme explicitly and implicitly has long held this view and whenever the words family planning are mentioned even in the latest documents the idea of population control follows. It is true that if all families are involved in planning their families then the population growth of the country (India for example) will certainly start declining. But on the other hand what actually has happened is that with the objective of population control, coercive contraception has often been practiced in the name of family planning. It must be clearly understood that while population control reveals a national concern while family planning is strictly restricted to decision making at the family level. While family planning assists in population control the two are in no way synonymous.

Population Discourse in India

India is well known as the first country in the world to have adopted a Family Planning in India. But this policy was backed by a long history of population related thinking and action within the country. The debate on whether the population growth in the

country was too high was started in the 1930's . It was also concurrently argued that India was the wealthiest country in the world with the poorest people, and the Nationalist minded held that Independence would tilt the balance. At the same time many organisations were founded on Malthusian lines and started working for family planning and population control. Subhas Chandra Bose and Jawaharlal Nehru were also strong advocates of family planning. The objective of most of these efforts were to ensure greater socio-economic development. It must be noted that the initial impetus to population control came entirely from Indian concerns for development. Later on the programme and policies became influenced by foreign experts and donor organisations which helped by introducing an extension based approach but also introduced the much maligned target based monitoring system.

Much has been written about India's Family Planning Programme - justifying its successes as well as some of its major shortcomings, and the interested reader may refer to some the excellent papers on the subject. But one thing that was becoming increasingly clear that Family Planning and its targets was becoming an obsession with the administration- right from Districts Magistrates/Collectors to lowly village level functionaries. Under the pressure to obtain the right targets all forms of practices from persuasion to pressure to blackmail was being used to get women under the surgeons scalpel, while surgeon in many cases threw basic aseptic and surgical norms to the wind to increase their tallies and records. In this hurry many women well past menopause were sterilised, others underwent multiple sterilisations and untold millions underwent other major and minor complications. And almost all these were women. In the madness of chasing family planning targets women's health took a back seat. Despite some achievements in lowering birth rates India's Family Planning programme had begun to draw flak from within and outside the country, particularly from women's health activists who demanded greater attention to women's health needs and a shift away from the method specific target fever which used to grip the nation between January and March. The ICPD was a much needed boost to the concerned citizens of the country because with it came many much needed changes in the programme. These will be discussed in the section on Reproductive Health- Policy and Advocacy .

No discussion on Population Programmes in India can be complete without a mention of Kerala. Kerala's performance in the population control front is seen as an oasis in the other wise barren landscape in India. The various studies and articles on Kerala's remarkable demographic parameters have very clearly brought out the fact that these were not due in any way to the National Family Planning Programme but to the socio-economic-political conditions prevailing in the state. In fact comparing Kerala with the program in China clearly outlines some of the shortcomings of a state sponsored family planning programme for controlling birth rates and family sizes. Notably the position of women in Kerala is far superior to that in China.

Section Three

Working On Population Related Areas

As has been mentioned earlier Population and Demography is essentially a multidisciplinary subject and there are a large number of disciplines involved . In India the study of population has been particularly significant because of our large population and in order to devise ways and means to control the growth in numbers as well as finding development solutions. There are many policy research and think tank group engaged in working on the myriad of issues . Names and addresses of different organisations working on the issue concerning population and demography from different perspectives is given below. This list does not purport to be a complete list in any way.

Organisations working on Population related areas

Centre for Development Studies , Thiruvananthapuram	Prashanthanagar, Ulloor, Thiruvananthapuram, Kerala-695011
Centre for Operations Research Training (CORT)	405, Woodland Apartment, Race Course Road, Vadodra – 390007, Gujarat Ph-0265-326453/326034/336875
Centre for Social and Technical Change (SOCTEC)	14, Bandstand Apartments, B.J. Road, Bandra (W), Mumbai-400050 Email- soctec@giasbm01.vsnl.net.in
Foundation for Research in Health Systems	6, Gurukripa, Apartments, 183, Azad Society, Ahmedabad, 380015 Email- frhsad@ad01.vsnl.net.in
Gujrat Institute of Development Research	Gota Char rasata, Gota, Ahmedabad-380481, Ph-079-474809
HEALTHWATCH	C/o Vimala Ramachandran 10 B Vivekananda Marg, Jaipur, 302001, Ph-0141-360158
IIHMR	1, Prabhu Dayal Marg, Sanganer Airport, Jaipur-302011, Rajasthan Email- root@iihmr.sirdnetd.ernet.in
IIM,Ahmedabad	Public Systems Group, IIM Vastrapur,

	Ahmedabad- 380015 Ph-079 407241
Institute of Economic Growth	Delhi University Enclave, Delhi- 110007
Institute of Health Systems	5-10-193, HACA Bhawan, Opp. Public Garden, Ground Floor, Hyderabad- 500004 Email- his.ihsnet@axcess.net.in
International Institute of Population Sciences	Govandi Station Road, Deonar, Mumbai-400088 Ph-022-5563254-56
Institute of Social Studies Trust	East Court, Upper Ground Floor, Zone 6A, India Habitat Centre, Lodi Road, New Delhi 110003, Ph- 011-4641083
Ministry of Health and Family Welfare	Nirman Bhawan, ? New Delhi -110001
Operations Research Group	Rameshwar Estate, Subhanpura, Vadodra, Gujarat, Ph-0265-381461/76
Population Council	Zone 5A, Ground Floor, India Habitat Centre, Lodi Road, New Delhi -110003. Ph-011-4642901/02
Population Foundation of India	B-28, Qutab Institutional Area, Tara Crescent, New Delhi 110016. Email-popfound@del2.vsnl.net.in
Population Resource/Research Centres of Different Universities and States	
Tata Institute of Social Sciences	Sion - Trombay Road, Deonar, Mumbai 400088. Ph 022-5563290
UNFPA	55 Lodi Estate, New Delhi 110003, Ph -011-4628877/4627702
USAID	Qutab Hotel Road, New Delhi -110016, Ph-011-6856301
World Bank	New Delhi Office, 70 Lodi Estate, New Delhi 110003, Ph 011-4617241

RESOURCE SECTION

Books for Further Reading

As population studies and demography cuts across a large number of disciplines, the number and variety of books that one can read is consequently very large. Some of the books we found useful were:

For understanding demography, particularly the technical side-

Reading Material for the Distant Learning Course for Master of Population Sciences of the IIPS

For Perspective on Population related debates-

- Desai Sonalde 1994,- Gender Inequalities and Demographic Behaviour : India , New York , Population Council
- Dixon -Muller, Ruth-1993. Population Policy and Women's Right: Transforming Reproductive Choice . Westport, Connecticut: Praeger
- Erlich, P.R. and A.H. Elrich. 1990. The Population Explosion. New York: Simon and Schuster.
- Gaia Atlas of Planet Management , Pan.
- Heyser Noleen 1996- The Balancing Act- MacArthur International Lecture series
- Lappe, F.M. and Schurman, R. 1989. Taking Population Seriously. London: Earthscan Publications Ltd.
- Sen Amartya - (Various books and papers)
- Sen, Germaine and Chen (eds), 1994 - Population Policies Reconsidered: Health, Empowerment and Rights , Cambridge , Mass, Harvard University Press

Population situation in India -

- Srinivasan K, 1995 - Regulating Reproduction in India's Population, New Delhi, Sage Publications
- Satia and Jeejeebhoy 1991. -The Demographic Challenge : A Study of Four Large Indian States- Bombay, OUP
- Anirudh Jain (ed) 1998-Do Population Policies Matter - New York, Population Council

Demographic Data about India

- National Family Health Survey Reports (1992 -93) – IIPS, Mumbai.
- Health Monitor (Annual Publications) – Foundation for Research in Health Systems.
- District Census Handbooks and data on Floppy

Journals-

These are some of the Journals that carry articles about demography and population studies:

- Economic and Political Weekly
 - Reproductive Health Matters
 - Population and Development Review
 - Population Studies
 - Studies in Family Planning
 - International Family Planning Perspectives
 - Demography
 - Population Bulletin
 - Demography India
 - Population Reports
-



**Understanding
Reproductive Health**

A Resource Pack

Booklet –Five

Women's Health –1

Maternal Health is still Important

SAHAYOG

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INTRODUCTION

The health of mothers has been a subject of national interest in India since independence. Mention has been made time and again in different documents of how crucially important the health of mothers is for the health of the children and of the future generations. Specially targetted programmes have been implemented within the larger family planning programme looking after maternal health. But over the last fifteen years or so there has been a growing unease (all over the world) over the exclusive concern for women only as mothers or potential mothers (cases for contraception). This single-minded attention to only one aspect of a woman's life and health also reflects the overall value that society placed on women.

Women's health is a very complex issue- it is influenced by a host of social and economic issues. In the patriarchal social setup that we live in, women's own perception of their bodies and health is very low, and it is controlled and mediated by numerous mores and practices. In such a situation women often do not even bring forward different complaints – especially if these have any thing to do with their reproductive tract. Women's reproductive morbidity has been referred to as a silent emergency, taking into consideration how widespread and serious the problem is. Current evidence indicates that it is not just the burden of reproductive morbidities that women, have to silently bear, but some so-called public health diseases too show increasing preponderance in women, not because of their sex but because of gender.

We have tried to cover the different issue and concerns around women's health in two booklets. The first booklet tries covers some of the basic determinants of women's health along with maternal health, while the second booklet deals with issues like abortion, infertility, cancers and so on. As in other booklets of this Resource Pack we have included brief profiles of organisations working on the issue as well as different resource material that is available.

Section One

UNDERSTANDING WOMEN'S HEALTH

What is Women's Health? : The term women's health is complex issue and encompasses the entire gamut of social cultural and medical aspects of a woman's life, which affect her health – either positively or more often negatively. It has now been clearly established that the socio-cultural determinants of health are equally important as the bio-medical determinants. This is more so in the case of women whose lives are controlled by numerous social norms and practices. For understanding these controls we need to look no further than the different customs and taboos associated with menstruation, pregnancy and childbirth. Examples of how other socio-economic factors affect women's health will be discussed at greater length later.

The term women's health has also to be understood with reference to some other popular terms like maternal health and reproductive health. **Maternal health** is the oldest of these concepts and clearly relates to health of women those who are involved in bearing children. It excludes the health of a whole range of women who cannot, do not want to, or are simply not involved in the process of becoming mothers. Therefore it excludes a large group of women – all their lives (women who are infertile or do not choose to bear children), and all other women for most of their lives (as adolescents, adults not in the process of bearing children, or older women). Hence it can be argued that following an exclusive maternal health approach limits the system to viewing, or giving importance to women only as child producers. This reflects the intrinsic value such a system places on women. Looking only or mostly at women as potential cases for contraception is an extension of this limiting approach.

The term **reproductive health** has arrived recently in India. Though this term is equally applicable to men and women, its use is often more closely associated with women. The International Conference on Population and Development has defined reproductive health *as a state of complete physical, mental and social well-being in all matters relating to the reproductive system and to its functions and processes*. When applied to women the canvas of reproductive health is much wider as it includes women who are suffering from gynaecological morbidities like reproductive tract infections, cancers, infertility and so on. It also addresses the health problems of adolescents. Maternal health is part and parcel of reproductive health. The framework of reproductive health includes the socio-economic determinants that have been mentioned earlier. The only limitation of this concept is that it is restricted to the health concerns around reproduction .

Unfortunately, despite all the hullabaloo over the new Reproductive and Child Health (RCH) programme, for many people in establishment reproductive health is just a new name for maternal health and family planning.

Women's health not only includes reproductive health and maternal health but also includes other concerns, which are generally seen as public health concerns. Thus any health problem/situation which affects women due to their gender are included within women's health. There is increasing evidence to show that women are more susceptible

to a number of health conditions because of the differential gender relations which include poverty, workload, violence, lack of decision making and so on. Thus if women suffer from tuberculosis due to certain circumstances which have to do with them being women, then it is a women's health issue. Similarly with malnutrition. In some countries of the world women's activists have got together and advocated for separate women's health policies. Three countries where such policies have been framed are Brazil, Australia and Columbia and South Africa is in the process of doing so.

Women's health and the socio-cultural context – The relationship between the socio-cultural situation in which a woman is and her health are very closely inter-related. Earlier there was a tendency to view health purely in bio-medical terms, but there is an increasing awareness that a woman's health is a product of complex social, economic and cultural (perhaps even political) circumstances in which she lives. While these factors affect the health of all individuals they affect women's health more. Some of the different socio-cultural factors affecting women's health could be seen as follows – economic situation, education, religion, cultural mores, patriarchy, mobility and so on. Interestingly socio-cultural conditions are not just contributing factors but consequences as well of women's health situation. A small example will illustrate this situation. Son preference leads to a woman undergoing repeated pregnancies and/selective abortions. Due to the inability to bear sons, she also has to face social alienation and even desertion. And this is just one example.

Gender And Women's Health : In India (as in many other countries) women's low social, political, legal and economic status contribute to the health problems of girls and women. Unequal gender relations are one of the strongest determinants of women's health. Right from the womb there are a number of gender based discriminations which affect women's health. Selective female infanticide and female foeticide is common in our country. It is common knowledge that girl children are given less care and nutrition and are less educated. The work load of women is greater from childhood itself- work they hardly get credit for. Then there are numerous restrictions – during menstruation, during pregnancy, and during lactation. Added to this women are rarely allowed to influence decisions in the family and community. They often have no rights under traditional laws and have no control over money or other resources. All these factors contribute to women's poor health in numerous ways -by preventing them from getting timely or adequate medical care, limiting the amount of money that can be spent on food or other necessities for women, and of course subjecting their bodies to far greater wear and tear. There is a basic inequality between men and women in which-

- more women than men suffer from poverty,
- more women than men are denied the education and skills to support themselves,
- more women than men lack access to important health information and services,
- more women than men lack control over their basic health care decisions.

And as mentioned earlier these inequalities affect their state of health. Usually, except for women's reproductive abilities, the health needs and concerns of men and women are considered equivalent if not the same. But women are not only biologically different from men, they are socially, politically, and economically different. Women's roles, and way

they are treated is different from men, both at home and within society . There are many health consequences of such inequality. Fortunately the ICPD has included gender as one of the important determinants of reproductive health, but time alone will tell whether this important principle of the Cairo agenda gets into practice in our country's programmes.

Women's health and the health care delivery system – The quality of health care women usually receive is unsatisfactory at almost all levels. Most health care service providers from nurses to doctors are all trained in the bio-medical causation of disease and are inexperienced about the different socio-cultural factors that affect women's health. This often leads to a gross insensitivity to women's health needs, and this is reflected in their treatment of their clients needs in terms of quality of service and nature of advice. The problem partly lies with limited availability of resources but the limited professional skills of health service personnel plays a major role in it. There is an urgent need to take certain measures in changing the situation. First and foremost among them is to provide upgraded training to health professionals (at all levels- especially at the level of ANMs, nurses and PHC doctors) so that they can improve and update medical skills. Secondly the service providers need to be reoriented in such a way, that helps them to develop their social understanding of women's problems and increase skills in better communication, so as to sharpen their ability to identify women's needs and understand their problems. This will enable them in delivering services in a more women centred /friendly manner.

Any health policy or programme which aims to deliver women sensitive health services should have following elements. It should -

- be gender sensitive,
- respect diversity of women's health need,
- respect women's cultures and local health traditions,
- be based on epidemiological and women's expressed health needs,
- keep socio-political reality of women in mind, and finally
- have intersectoral coordination of all policies and programmes affecting women's health.

Women's Perception Of Their Bodies : As human beings our perceptions of things is mediated by how society, the people around us view certain things. Likewise women's perceptions of their bodies is not really *their* own perception only but a conforming version of what society perceives in general. Society sets standards which are considered normal and anything differing from that standard is not normal giving rise to a sense of inadequacy in many women. Different social institutions and factors play a vital role in setting standards and in defining what is normal. Among these the role of the media (print and A\V), market (advertisements, beauty pageants), peer group and marriage market are some of the most influential. Women's self worth is also shaped by the numerous inequalities they see and experience being in the family and in society right from early infancy, if not from the womb. All this leads to a feeling of general low self worth.

The case is even worse as far as their reproductive organs are concerned. In this context women's bodies and its bodily processes are considered shameful and defiling in most

Indian cultures. Consequently women shrink in and are segregated to their little spaces during menstruation, pregnancy and childbirth. For example shame and pollution are obvious in most menstrual practices and taboos. Pollution comes to the forefront even during advanced stages of pregnancy and after childbirth. The new-born infant and mother are often considered impure and polluting until they have taken a purifying bath some days later.

Since women's bodies are devalued in society very little information is given to a girl about her body and its bodily processes. She grows up hardly knowing anything about the form and substance she is devalued for, but the sense of devaluation is very strong. Soon she also starts disapproving of her own body. This sense of alienation from her body affects her health seeking behaviour also. She does not give much importance to her ailing state, and hence seeks no remedy to overcome her illnesses. This is particularly seen in her phenomenal silence about gynaecological morbidities.

Menarche, Menstruation and Menopause: The biological difference between men and women is primarily in the way their reproductive organs are made and in the way they function. The obvious physical characteristics/differences of the male and female are divided into primary and secondary sexual characteristics – primary being those which are evident from birth (genitals) and secondary being those which become evident after puberty (body hair, breasts, timbre of the voice etc.) Menstruation and child-bearing are two fundamental process differences between the two sexes. In bio-medical terms menstruation is the periodic shedding of the uterine lining approximately every 25-30 days for 3-7 days. Menarche is the time when this process first starts. The usual range being between 10-16 years and menopause the time menstruation finally stops. This usually takes place anywhere between of 40-45 years, even 50 in some women. And all this is common knowledge.

Menarche, menstruation, and menopause are not just biological events but social events as well. Among these three the social consequences of menstruation are perhaps the most all pervading. Firstly there is ignorance and incomplete knowledge about the biological basis of menstruation among women in general and young girls in particular. Then there are the numerous misconceptions. And this is true not only of a conservative society like India but also of a more open, free and progressive society like America as shown by Koff and Rierdan (1995). They found that school going young girls who view themselves as “prepared” for menarche not only have incomplete knowledge about process of menstruation and possess a variety of misconceptions but also their knowledge of the location and function of reproductive structure was faulty and most did not understand how reproductive structures are interrelated.

The situation in India is worse. The socio-cultural norms and practices associated with menstruation in India have made it an unwelcome and often disgusting experience for women. Despite the fact that onset of puberty (and menarche) is celebrated in some parts of country, a menstruating woman is often considered polluting, impure and unholy. She is often not allowed to participate in religious or social functions and restrictions are placed in terms of living space, mobility, diet and so on. In other places an unmarried

girl's menstruation is not acknowledged even by her mother (if it is, then she starts becoming impure) and society colludes in maintaining this secret. Interestingly in this very society, the menstrual cycle of each married woman is observed very closely by community elders. It is also common practice in this society to celebrate when the daughter-in-law has her first period (perhaps a symbolic menarche celebration). (Dasgupta and Das 1998)

Studies (Chaturvedi and Chaturvedi 1991; Sveinsdottir 1993;) have also shown that socio-cultural and biological problems or comforts faced by a menstruating woman define her attitude towards menstruation. Women who report considerable menstrual problems consider menstruation to be "debilitating" and have an "unhealthy" attitude whereas those who have premenstrual well-being consider menstruation to be a natural event and have a "healthy" attitude.

Menstrual Problems - Pain or general discomfort (cramps, backache and breast tenderness) felt by some women around the time of menstruation is known as dysmenorrhea. Some premenstrual symptoms (bloated feeling, some weight gain, headache, irritability, mood changes etc.) may or may not associated with dysmenorrhea. There is no single cause for dysmenorrhea but water retention, hormonal imbalance and other chemical reasons are suggested as possible factors. Social perceptions also mediate the amount of pain and discomfort that is felt during this time. But menstrual pains can also be due to medical problems such as an infection, tumor or endometriosis. The term premenstrual syndrome or PMS is used to refer to those causes in which the woman has a particularly severe combination of physical and psychological symptoms (as mentioned above) premenstrually. Interestingly for a long time PMS was not accepted as a true health problem by the medical profession and was considered an imaginary situation or an over-reaction. It is important to realise that women who have repeated and severe discomfort and change in behavior before menstruation should be advised to seek specialised medical attention.

Menopausal problems are being dealt separately in the second booklet

Section Two

MATERNAL HEALTH AND SAFE MOTHERHOOD

The Importance of Safe Motherhood : According to WHO figures there is a great difference between the maternal mortality rate (MMR) of developed and developing countries. Maternal mortality being defined as the death of a woman while pregnant or within 42 days of the end of her pregnancy from any cause related to or made worse by the pregnancy, regardless of the duration of pregnancy. In developed countries 1 out of 1,800 women die from the complications of pregnancy and childbirth whereas in developing countries the risk is a far higher 1 out of 48. A regional variation of women's lifetime risk of dying from pregnancy and childbirth is given below-

Region	Risk of Maternal death
Africa	1 in 16
Asia	1 in 65
Latin America and Caribbean	1 in 130
Europe	1 in 1400
North America	1 in 3700

In India the lifetime risk of a woman dying from pregnancy or childbirth is about 1 in 37. and any risk more than 1 in 100 is considered high risk. The MMR in India is about 400 (per 100,000 live births) and this is probably a low figure because of the inadequate reporting system in our country. When going through these figures it is important to realise that this is the situation fifty years after the country accepted that maternal health would be a priority area of concern.

Reasons behind unsafe motherhood : The high risk of maternal mortality and morbidity are surely consequences the poor socio-economic situation in a country as is clearly illustrated in the figures given earlier. The availability or lack of trained personnel and equipped birthing facilities are also an important determinant of maternal safety. Young, poorly nourished, anaemic, multiparous (with low interval between childbirths) women with low social status and lack of appropriate knowledge about health, when pregnant have far greater chances of complicated pregnancy and delivery. It is difficult to predict complications in many cases. But the delay and appropriateness of decision making which often depends on the economic situation, the availability of appropriate emergency services, the communities faith in them, and the intrinsic value of the woman concerned, makes the difference between life and death for the mother.

In India, the incidences of early marriage and childbirth are so high that they pose a serious threat to the life of the mother and the child in question. This teenage pregnancy is not only socially sanctioned but in many communities is seen as ideal. We have a law regarding the minimum age at marriage, but this legal restriction has made little difference because of the lack of political will to enforce it. Health care service delivery is extremely poor despite years of pursuing a maternal health agenda. Antenatal care is restricted to anti-tetanus injections and an overwhelming majority of childbirths take

place under the supervision of untrained attendants. Even so-called trained attendants leave all their training behind when actually conducting the delivery. Referral facilities are often ill-equipped and the current promises of FRUs (First Referral Units) and EmOCs (Emergency Obstetric Centres are the only hope millions of Indian women are looking forward to.

Box – Common causes of Maternal death

The main causes of maternal mortality may be divided into 3 categories - social, medical and available health care facilities.

Among the social causes are

- early marriage and pregnancy,
- repeated childbirth, son preference, anaemia,
- lack of information,
- ignorance and so on.

Among the medical causes are

obstructed labour,
haemorrhage,
toxemia and
infection.

And among available health care facilities are

- lack of essential supplies and trained health personnel at the centers,
- non-sympathetic attitude of health personnel,
- deficient medical treatment of complications and
- inadequate action taken by medical personnel.

(Safe Motherhood in India 1994; The Need for Comprehensive Policy and Programmes 1994).

Ensuring Safe Motherhood : Safe motherhood means ensuring that all women have access to the information and services they need to go safely through pregnancy and childbirth. As outlined in the ICPD (PoA), maternal health services should include

- education on safe motherhood,
- prenatal care and counselling with focus on high risk pregnancies,
- promotion of maternal nutrition,
- adequate delivery assistance in all cases,
- provisions for obstetric emergencies including referral services for pregnancy, childbirth and abortion complications,
- post natal care

Antenatal Care : Infant and maternal mortality rates (IMR and MMR) of a country

reflect the socio-economic development, accessibility to health care and nutritional status of that country. Hence IMR and MMR which still remain pretty high in India not only represent a loss of precious lives, but also discredit India's health and welfare programmes. Such a high rate of IMR in India persists for want of political will, professional commitment and people's action. Though with the implementation of different programmes related to maternal and child health there has been some reduction in IMR and MMR but it is far from adequate. Proper antenatal care (ANC) is perhaps one of the first things that can assist in this direction.

Ante natal care refers to health education and regular medical check-ups given to a pregnant woman in order to make the outcome of the pregnancy safer. ANC is also necessary to screen high risk pregnancy (HRP) and high risk labour signs. Regular check-ups done during pregnancy include history taking of any past and present pregnancy related problems, abdominal examination, height and weight monitoring, monitoring of blood pressure, testing for protein in urine and so on. Most of these tests are very simple and can be done with minimal training. Nutritional and other relevant counselling and provision of tetanus toxoid injections are also part of mandatory antenatal care. ANC can help reduce cases of maternal morbidity and mortality through early detection and treatment of pregnancy related common, and by identifying the women at increased risk of complications of delivery. The task of high-risk screening can be done by the most peripheral health worker.

In India within the given socio-cultural milieu regular check-up during pregnancy are still not considered a desired practice in many parts of the country. Any kind of check-up or preparation to deal with emergency is seen as an ill-omen, something that will bring on the mishap. But even for those who would not mind getting the service, the moribund state of the health system in many parts of the country, ensures that this simple but essential ante-natal care, is not available to millions of women in the country.

Supplementary Programmes of the Government- To achieve the goal of Safe Motherhood the government has implemented many schemes and benefits which aim at the health of mother and child. These benefits are part of the Mother and Child Health package of the Department of Family Welfare. In the recent past the package has been renamed from the CSSM (Child Survival and Safe Motherhood Programme) to the RCH (Reproductive and Child Health Programme). In actual terms the services are mostly limited to the provision that every pregnant woman gets 2 Tetanus Toxoid injections and 100 tablets of iron folic acid tablets. In many places the regular check-ups for high risk screening are not done. Besides this the government also has Maternity Benefit Act 1961 under which 3 months maternity leaves are given to all pregnant women working in organized/ unorganized sector who have worked for a period of at least 80 days with the present employer. Another scheme called the National Maternity Benefit Scheme provides women above 19 years and living below the poverty line, financial aid of Rs.300/- for her first two children .

Care during Childbirth : Childbirth is a normal physiological process and in most cases it happens without any mishap. It is only in some situations where problems occur, and it

is necessary to have possible arrangements available to take care of these problems. Physiologically labour consists of three stages, in the first stage there are contractions of the uterine muscles, leading to labour pains. In the second stage the baby is pushed through the now fully opened cervix through the vagina and into the outside world. And in the third stage there is separation of the placenta from the uterine wall and its passing of it out of the body as the "afterbirth".

This bio-medical description of labour differs significantly from the socio-cultural aspects of labour. Practices related to child birth differ from region to region and some are beneficial and some are harmful. For example conducting delivery in unclean surroundings (for child birth is considered impure and defiling), cutting the cord with unsterile sickle or knife and applying dung or turmeric on the placenta are unsafe. On the other hand there are practices which are women centered and healthy for example, squatting position during labour, massaging the back of the woman, giving her something hot to drink and so on.

There are differing points of view on whether labour is best conducted in an institution under technologically managed conditions or under more natural surroundings. But one thing is certain, if we have ensure safety it is essential to have expert obstetrical support close at hand, in case there are any problems. Unfortunately there are a number of labour related complications which cannot be predicted. For real-life situations in rural India the best option is to have a trained person conducting the delivery, with a clear emergency plan chalked out before hand. The FRUs and the EmOCs that the Government has promised, when functioning will prove the best bet for managing emergencies.

Box – Natural and other forms of Childbirth

In this modern technological age there is an increasing demand for universalisation of institutionalized delivery so that many of the complications can be can be adequately handled. On the other hand there is small but vocal view point view point of home deliveries, championed by feminists. Their argument is that if due care is taken before and during delivery then conducting deliveries at home is perhaps best for the mother and the child. According to this point of view institutionalized deliveries not only deprive women of a comforting and supportive atmosphere(of people, surroundings etc.) but also lithotomy position (in which many institutional deliveries take place where the womens legs are hiked up and put in stirrups) is not woman friendly, and only keeps doctor's convenience in mind.

The focus of most prepared childbirth methods has been two-fold : drugless techniques that minimize pain, and education regarding the birth process. The first such method introduced by G. Dick-Read in 1933 advocated the use of relaxation and deep breathing, believing pain to be a product of fear and tension. Then F. Lamaze talked about different types of exercise. Then there was R. Bradely, the founder of "husband-coached childbirth" who advocated slower, deeper breathing exercises for this purpose. Michel Odent emphasized privacy and darkness to facilitate the natural process and advocated the use of water pools in labour.

In all these methods the emphasis of giving control of the birth process to the mother. Thus birth becomes more than just a hospital procedure. The essence of these methods or “natural childbirth” is respect for the wisdom of the birthing process, trusting nature to work in the most efficient way for each particular mother and child. When a woman is taught to move beyond pain and fear, she can then work in harmony with her labour, reducing or eliminating the use of interventions. She can be mobile throughout the labour, can choose positions that allow gravity to assist the birth process, and she can be fully conscious to appreciate the coming of the baby. These methods do not have many followers in India, but many of our traditional birthing practices also use some of these principles. (end of box)

Post Partum Care : The six-week period after the birth of the baby during which the mother’s body gradually returns to non-pregnant state, and she adjusts to the presence of the baby in her life and in the life of her family is known as post partum period and care provided during all this is called post partum care (PPC). After delivery a woman has to make both physical and emotional adjustments and she needs support and understanding. Some of the medical disorder during this are puerperal sepsis or infection of the uterus and surrounding tissues, urinary infection, acute prolapse of the cervix and puerperal psychiatric illness. It is important to diagnose and treat these conditions as early as possible as some of these may lead to more serious/life threatening complications

Soon after delivery many women feel slightly depressed, scared or low and experience mood swings. Irritability, difficulty in sleeping, crying, uncertainty and loneliness are some of the other problems women sometimes go through. The main reasons cited for these feelings are hormonal changes and the adjustment to a new schedule. Women usually overcome these feelings with rest, comfort and support in caring for the baby but if these persist then professional counseling should be sought. Post partum care includes the mother’s recovery to normal physiology, establishing healthy breastfeeding and contraception and not just the treatment of complications like haemorrhage and sepsis.

Box – Elements of Post partum care

The elements of post partum care are -

- medical management of post partal complication / morbidities,
- promotion of optimum practices of breastfeeding,
- timely and appropriate choice of contraceptives,
- promotion of adequate rest ,diet and hygiene of the mother,
- promotion of timely immunization.

As with pregnancy and labour , different regions of our country have a host of cultural/traditional practices for the post partum period. Many of these affect the health and wellbeing of the mother and the child adversely, while others are beneficial. Much of the attention in the postpartum care is focussed on the well being of the child. Care of the mother is a relatively neglected area. And this true both for traditional practices as well as for the health services.

India has been implementing a Post Partum Programme since 1966 as a part of a global experiment. The main objective of this programme was to motivate women within the reproductive age group of 15-44 years, and also their husbands to adopt the small family norm. This was to be achieved through "education and motivation during antenatal, natal and post partum and after medical termination of pregnancy (MTP)." The programme set out to provide an integrated package of maternal and child health and family welfare services, including information, education and communication activities through a hospital based post partum centres.

Section Three

IMPLEMENTING A MATERNAL HEALTH PROGRAMME

Maternal and Child Health Programmes are among the commonest interventions in the sector of Health by NGOs in India. Earlier the trend was to run charitable clinics and hospitals but over the years MCH programmes have become more prominent. As it has been already mentioned the condition of the state-run health services are so poor in many parts of the country that poor women in the rural communities seldom get access to the various schemes and programmes meant for them. The economically well off not only get better services from the state functionaries but they also access private services elsewhere. It has already been mentioned that the Maternal Mortality figures in India are pretty high. Thus even in the age of Reproductive and Child Health (the new Government programme) the need for an effective Maternal Health programme cannot be over-emphasised.

Despite the over-medicalisation of pregnancy and childbirth in urban areas, a large proportion of pregnancies and childbirths can take place with the minimum of trained supervision. Fortunately it is possible to run an effective maternal care programme with paramedics and nurses but with an effective referral support system. It must be mentioned here that the effectiveness of such a programme does not lie in technical expertise, but often on the degree to which the programme is able to identify with the communities and vice-versa.

Understanding The Community - On the technical front the programme may be reduced to a set of simple discrete activities like –

- identification of pregnant women;
- providing at least three check-ups for high risk screening;
- providing tetanus toxoid injections, iron and folic acid tablets; and
- giving the relevant health education about rest, diet, travelling, medicine intake, intercourse and so on.

But if the programme is taken up in a mechanical manner not taking into consideration the actual reality within which the pregnant woman lives, it might not succeed, just like the government programme. In some places it might be culturally inappropriate for daughters in laws to rest during the day. In others it might be that some food items are proscribed which we would like her to include in her diet and so on. In such a situation it is essential to first understand what the normative beliefs and practices are in the realm of mother care before embarking on any health education programme. The community cannot be just directed to adopt some new practices without first resolving the conflicts with their earlier traditions.

The first step is to realise that getting the community to adopt new behaviour is complex and there are no ready made answers. One has to explore the existing social and cultural norms, beliefs and practices around the issues of pregnancy, childbirth and care after birth. The community itself needs to be thoroughly convinced on the need to change behaviour and practices, before it will willingly do so. Participatory Rural Appraisal is a

useful method to jointly analyse the problem with the communities for future planning and interventions.

Strengthening Community Capacities- Training TBAs - It is being increasingly realised that with the kind of health services that we have at present, strengthening the local capacities is one of the most effective ways of ensuring sustainability of the intervention. Besides it also encourages self-reliance a virtue that has been systematically undermined by the state-driven development initiatives. Traditional Birth Attendants (TBAs) are often considered the cornerstone of any effort towards sustainability and self-reliance in the sphere of maternal care.

In large parts of India the facilities for institutional deliveries just do not exist and thus home based deliveries will continue to remain the norm for large number of Indian women. Training TBAs in conducting safe deliveries assumes great importance in this context. But it must be remembered that in many places it is often the mother-in-law or any older woman who assists during the childbirth. In many places dais belong to a specific caste (often lower castes) and their role in childbirth is very limited. One should understand the existing situation in the community before adopting a universal pattern of TBA training. While arranging TBA training it must be kept in mind whether we want to train them afresh or build on their existing skills. Much has been mentioned of the five cleans, but unfortunately TBA training programmes all over have often resulted in TBAs losing some of their vital skills especially with respect to their woman-centered-ness while acquiring some extremely bad hospital practices. For example instead of waiting for labour to take its normal time they insist on giving pain inducing injections or prefer lithotomy position over sitting or squatting position.

Preparing For Referral - A large proportion of life threatening events happen during labour. At this point in time preventive action is often of no use and the only way out is to seek expert medical help. Three things are crucial at this juncture once the danger has been recognised-

- to decide to seek expert help (often this depends on the men in the family, their attitude towards women and financial resources),
- have available means of transportation and
- visit a facility which is competent to handle the complication.

The FRUs and EmOCs mentioned earlier are meant for this purpose. But at the community /family level there must be adequate preparation before hand so delays may be avoided, decisions taken and the right place reached.

Dealing With Traditional Practices- up until some time ago traditional practices were uniformly considered harmful and all efforts at health education were directed at replacing them with modern scientific knowledge and practices. There is another school of thought where every thing traditional was revered. One has to be careful not to fall into either of the traps. There are a number of practices which are very useful and others which are equally harmful. Before either condemning or recommending, the particular practice must be clearly understood. Harmless or innocuous traditional practices are better left alone because changing an established pattern of behaviour can take a lot of

energy.

Box-

Health Education And Communication Strategies - Some points which could be kept in mind while formulating a health education and communication strategy are given below:

- It should respect local knowledge,
- It should keep local socio-cultural factors in mind,
- It should raise questions on existing gender, caste discriminatory practices,
- It should encourage people to raise questions on unhealthy practices relating to maternal health prevalent in the community. But that should be done only after giving scientific information on the issue,
- It should be such which is sensitive to otherwise marginalised sections of the society viz. women, dalits, minorities, illiterates etc. Promotional materials should have more visuals, should have signs to which these people relate to easily and should have names which are not necessarily referring to one particular community,
- It should be interactive, should not be one sided
- It should encourage people to think of solutions
- It should provide necessary health information and information about rights and services

Some Innovative Projects In The NGO Sector

There are a large number of voluntary organisations working in the field of safe motherhood. Here we provide an introduction to a few such interventions. This is no way a representative list of the different kinds of approaches and strategies that organisations such as these have adopted.

CINI , West Bengal.

Child in Need Institute(CINI) was started in 1974, and Maternal and Child Health is one of its main areas of work. Mahila mandals, or women's groups are given the responsibility of running the MCH programme at the village level. Services include growth monitoring, immunisation, ante-natal and post natal care, health education and low cost curative care. They also have a programme to support poor pregnant women.

Further details about their work may be obtained from :

Dr S.N. Chaudhury, Director,
CINI,
Village Daulatpur, P.O. Pailan via Joka,
Dist – 24 paraganas(s), West Bengal – 743512.
Email- cini@cal.vsnl.net.in

SEWA-Rural, Gujarat

Sewa-Rural is a unique organisation because the Gujarat government handed over the PHC to the organisation ten years ago. SEWA- Rural thus has to follow many government guidelines, and is a place to experience how the government system can function at its best. There is also a large hospital run by the organisation which provides essential referral services.

For further details contact:

Dr Lata Desai, Managing Trustee,
SEWA-Rural,
Jhagadia, Dist Bharuch,
Gujarat- 393110

VGKK, B.R.Hills, Karnataka

Vivekananda Girjana Kalyan Kendra is an organisation working exclusively with the Soliga tribals in Mysore district. The organisation has been experimenting to integrate tribal herbal systems of medicine with modern medicine in its MCH programmes. They are also involved in training tribal girls as ANMs. The MCH programme is part of a larger community health work.

For more details contact:

Dr H Sudarshan,
Director, VGKK,
B.R.Hills, Yelandur Taluka,
District Mysore, Karnataka-571441
email-

Sewa Mandir, Rajasthan.

Sewa Mandir, was set up thirty years ago and works primarily in the tribal areas of Udaipur district. Its MCH is based on a cadre of primarily male village level workers. Besides TBA training Sewa Mandir is also involved in providing referral support through ayurveda. They have also initiated a form of health insurance sheme where families have to pay a membership fee for accessing services.

For further information please contact:

Shri Ajay S Mehta,
Director,
Sewa Mandir,
Fatehpura,
Udaipur, Rajasthan 313001.

RESOURCE SECTION

Further Reading : Some of the books that we found useful in preparing this booklet were:

- | | | |
|--------------------------------------------|------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Akhter, H.H. and T.F. Khan | 1997 | Selected Reproductive Health Elements and Interventions. Dhaka: BIRPERHT. |
| Arkutu, A.A. | 1995 | Healthy Women, Healthy Mothers. NY : Family care International. |
| Boston Women's Health Book Collective, The | 1998 | Our Bodies Ourselves. NY : Touchstone Rockefeller Centre. |
| Carrera, M.A. | 1992 | The Wordsworth Dictionary of Sexual Terms. Herfordshire : Cumberland House. |
| Chaturvedi, K.S. and P.S. Chandra | 1991 | "Socio-cultural Aspects of Menstrual Attitudes and Premenstrual Experiences in India". Social Science Medicine 32 (3):349-351. |
| Chawla, J. | 1994 | Child Bearing and Culture. N.Delhi : Indian Social Institute. |
| CHETNA | 1994 | Thematic Meeting on Reproductive Health : The need for Comprehensive Policy and Programme. Ahmedabad : CHETNA. |
| Family Care International | | Sexual and Reproductive Health Briefing Card. |
| Hyman, J.W. and E.R. Rome | 1995 | Sacrificing Ourselves for Love. California : The Crossing Press. |
| Jeffery, P. et.al. | 1985 | Contaminating States and Women's Status. N.Delhi : Indian Social Institute. |
| Joshi, A. et.al. | | Socio-cultural Implications of Menstruation and Menstrual Problems on Rural Women's Lives and treatment Seeking Behaviour. Baroda : Operation Research Group. |
| Koff, E. and J. Rierdan | 1995 | "Early Adolescent Girls' Understanding of Menstruation" Women and Health 22(4): 1-21. |
| Ministry of H & FW (Bangladesh) | | Safe Motherhood. |
| Nobel Forum | 1994 | Safe Motherhood in India (Symposium Report). |
| Population Council | 1997 | A Reproductive Health Approach to Post Partum Care (Workshop Report). Population Council : S.E.A. Registered Office. |
| Sathyamala, C. et.al. | 1986 | Taking Sides. Madras : ANITRA |
| Shephard, B.D. and C.A. Shephard | 1990 | The Complete Guide to Woman's Health. NY : Penguin. |
| Weisenheimer, R. | 1994 | Dr. Ruth's Encyclopaedia of Sex. |
| Werner, D. | 1994 | Where There is no Doctor. Palo Alto: Hesperian Foundation. |

Werner, D. and B. Bower 1987 **Helping Health Workers Learn.** Palo Alto: Hesperian Foundation.
Where Women Have no Doctor. Palo Alto: Hesperian Foundation.

BOOKS IN HINDI

Shirali, K. et.al.

Eklavya

Eklavya

Stri Sharir Ki Pahchan (A set of 8 books). Jagjit Nagar Sutra.

Bitiya Kare Sawal. Devas: Eklavya.

Bitiya Bari Ho Gayi. Devas: Eklavya.

Some recent research articles on Maternal Health are:

Bhatia, Jagdish. 1993. "Levels and causes of maternal mortality in Southern India," *Studies in Family Planning*, 24, no. 5 (September-October).

Bhatia, J. C. 1988. *A Study of Maternal Mortality in Anantpur District, Andhra Pradesh, India.* Bangalore: Indian Institute of Management.

Bhatia, J. C., and John Cleland. 1999. "Health seeking behaviour of women and costs incurred: An analysis of prospective data," In Saroj Pachauri and Sangeeta Subramanian (Eds.) *Implementing s Reproductive Health Agenda in India: The Beginning*, The Population Council, New Delhi.

Bhatia, J. C. and John Cleland. 1994. "Obstetric morbidity in South India: Results from a community survey," *Social Science and Medicine*, 43, pp. 1507-1516.

Chhabra, Rami and S. C. Nuna. 1993. *Abortion in India: an Overview.* New Delhi: The Ford Foundation.

Ganatra BR, Hirve SS, Walawalkar S, Garda L, Rao VN (1998a): *Induced abortions in a rural community in western Maharashtra: Prevalence and patterns.* Ford Foundation Working Paper Series.

Ganatra, B. R., K. J. Coyaji, and V. N. Rao. 1998. "Too far, too little, too late: A community based Case Control Study of maternal mortality in rural West Maharashtra." *Bulletin of the WHO* 76, 6, pp 591-598.

Ganatra, B. R., and S. S. Hirve. 1995. "Unsafe motherhood: the determinants of maternal mortality." *Journal of the Indian Medical Association*, 93, 2, pp. 34-35.

Gupte Manisha, Bandewar Sunita, Pisal Hemlata (1999): *Women's Perspectives on the Quality of Health Care: Evidence from Rural Maharashtra.* In MA Koenig and ME Khan (ed) *Quality of Care within the Indian Family welfare Programme*, New York, Population Council. Forthcoming.

Gupte Manisha, Bandewar Sunita, Pisal Hemlata (1997): *Abortion Needs of Women: A case study of Rural Maharashtra.* *Reproductive Health Matters*. Vol 9, May 1997 pp 77-86.

International Institute of Population Sciences (IIPS). 1995. *National Family Health Survey (MCH and Family Planning), India 1992-93.* Bombay: IIPS.

Jejeebhoy, Shireen. 1999, "Women's autonomy in rural India: its dimensions, determinants and the influence of context", In Harriet Presser and Gita Sen, (Eds.) *Female Empowerment and Demographic Processes: Moving Beyond Cairo.* Clarendon Press, Oxford (forthcoming).

Mari Bhat, P. N., K. Navaneetham and S. Irudaya Rajan. 1995. "Maternal mortality in India: estimates from a regression model," *Studies in Family Planning*, vol. 26, no. 4, pp. 217-232 (July/ August).

McCarthy, James and Deborah Maine. 1992. "A framework for analysing the determinants of maternal mortality." *Studies in Family Planning*, 23, 1 (January-February).

Nag, Moni. 1994. "Beliefs and practices about food during pregnancy: implications for maternal nutrition " *Economic and Political Weekly*, XXIX, 37

Pachauri, Saroj. 1995. *Defining a Reproductive Health Package for India: A Proposed Framework*. South and East Asia Regional Working Paper 4. New Delhi: Population Council.

World Health Organisation. 1991. Maternal Mortality: A Global Factbook. Geneva, World Health Organisation.

RESOURCE ORGANISATIONS

There are a large number of organisations providing technical support on the issue of maternal health within the country. We are listing the names and addresses of some of these organisations here.

VHAI- As far as maternal health is concerned VHAI is important for the material that it publishes. VHAI is one of the best sources for slides on maternal and child health. Its newsletter Hamari Chithi Napke Naam , (and its various translations) is very useful for the village level health worker. The different state level VHAs are more useful as training resource organisations in the different states.

Voluntary Health Association of India,
Tong Swasthya Bhawan,
40-Institutional Area, (behind Kutab Hotel)
New Delhi -220026
Email-vhai@del2.vsnl.net.in

CHETNA – CHETNA is perhaps the most important NGO resource organisation on the issue of women's health in the country. They have large number of publications and material which is freely available by post on payment. For organisations in Rajasthan and Gujarat CHETNA provides resource support in the area of training in Maternal and Child Health. CHETNA has two units devoted exclusively to providing resource support in Women's Health and Children's Health.

CHETNA
Lilavatiben Lalbhai's Bungalow
Civil Camp Road, Shahibaug,
Ahmedabad
380004, Gujrat
Phone : (079) 786 8856, 786 5636
email: chetna@adinet.ernet.in

Various State Voluntary Health Associations – The state VHAs are important resource organisations for material and training support in the regional context and in the appropriate regional language. Addresses of the different state VHAs are available from VHAI.

SAHAYOG- is primarily involved in providing training and technical support and produced manuals and material for organisations in the Hindi speaking region.

SAHAYOG,
Premkuti, Pokharkhali,
Almora, U.P. 263601

Survival of Women and Children Foundation (SWACH)- SWACH is involved in adapting WHO material related to MCH for the Indian situation. They have available a number of pictorial and other material for TBAs. They are also involved in providing technical support to NGOs under Government sponsored projects.

SWACH,
Near Sanatan Dharam Mandir,
Sector 16, Panchkula, Haryana 134109

Ministry of Health and Family Welfare – The MOHFW is involved in preparing and distributing a large variety of pictorial and other material every year. The best way to access this material at the local level is from the office of Chief Medical Officer of the district.

Box- Resource Materials-

These include-

- Manuals – including training manuals and kits
- Flash cards, and flip books,
- Videos,
- Posters,
- Pamphlets,
- Weighing scales, and growth cards
- And so on.

All the different organisations listed above are actively involved in the preparation and distribution of such resource materials

Training Opportunities

ANM Training – Nursing schools attached to missionary and voluntary organisation hospitals are some of the best sources for training Auxilliary Nurses or even General nurse. These schools usually have their students sign a bond for a specified periods service in exchange for the free education. Many of these organisations take candidates sponsored by voluntary organisations. Kasturba Trust in Indore also runs such an ANM training institute.

Training of other field based workers- There are a large number of organisations providing training for field based MCH workers some of these are the State VHAs, CHETNA, SWACH, SAHAYOG SEWA-Rural, Comprehensive Rural Health Project (Jamkhed) PRERNA, (Lucknow) and so on. Many of these organisations also provide TBA Training.

Training of Managers- Training of managers for MCH programmes are less common and some of the organisations involved in providing such training are WAH! Programme, Institute of Health Management, Pachod and SEWA- Rural.

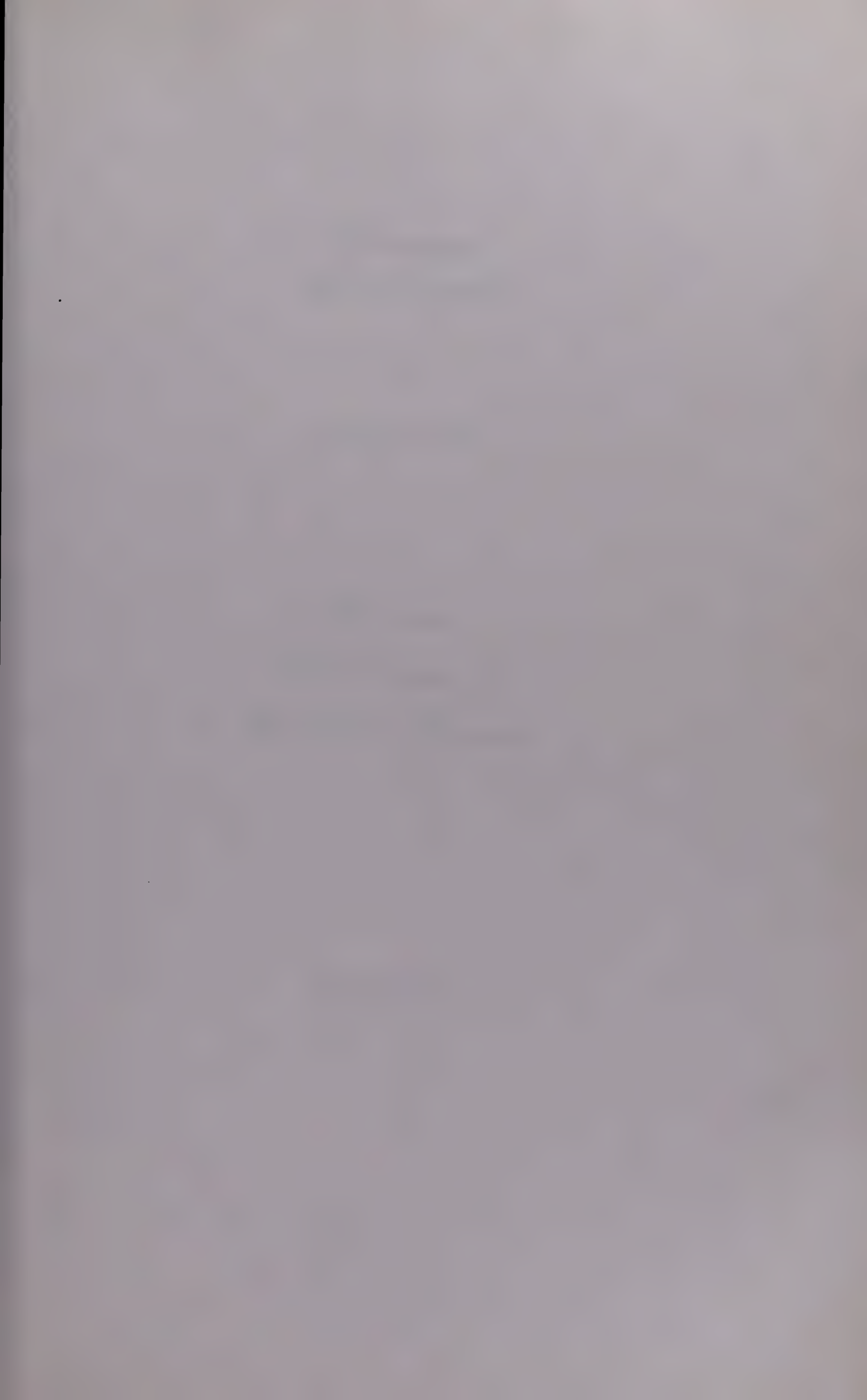
Addresses of the organisations referred to for the first time in this section are:

PRERNA	19, Laxman Puri, Faizabad Road Lucknow-226016, Uttar Pradesh Phone : 386715, 387884 Fax : 387884
IIHMR	Pachod District – Aurangabad-431121 Maharashtra Phone : 02431-21419,21382 email : ihmp@giaspn01.vsnl.net.in
CRHP	Comprehensive Rural Health Project, Jamkhed, Dist- Ahmednagar, Maharashtra –413201. Phone (02421) 21322, 21323 Fax- (02421) 21034
Kasturba Trust	Kasturba Trust, Indore, Maharashtra

Booklet prepared by:

Research and Text –Alka Agarwal, Abhijit Das, Jashodhara Dasgupta

Additional text and review – Dhamu Swadi, Bela Ganatra, Siddhi Hirve



**Understanding
Reproductive Health**

A Resource Pack

Booklet –Six

Women's Health - 2

The Promise of Better Health

SAHAYOG

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INTRODUCTION

Women's health for long was only important as far as her child-bearing capacities were concerned, and thus we had Maternal health and Family Planning. The whole concept of reproductive health emerged from the narrowness of this approach. While reproductive health is not broad enough to encompass all the health concerns of women, it certainly is a great step forward from the earlier narrow approach.

While formal medicine has a separate section devoted to the health or more properly the treatment of conditions in women which were specially concerned with their reproductive system (but not with child bearing)- gynaecology, reproductive health has allowed space for such health conditions to be dealt within a public health setup. But at the same time the women's health conditions as dealt within the ambit of reproductive health go far beyond mere gynaecology, because reproductive health is also concerned with the social determinants of health and disease. It has been shown by many social science researchers that the status of health that women enjoy, or conversely suffer from, correlates with their socio-economic condition, as well as the degree of gender related discrimination that is inherent within the family and society. Reproductive health acknowledges these constraints and is concerned with enabling women better health facilities (access, services and quality of care) as well as challenging and bringing about change in the social factors as well.

These social factors are not unique to either poor, or to India- they are more or less universal. The manifestations are different across space and time. And these social factors have been largely responsible why many of women's most acute health problems have not been considered important for so long a time. But now with more sensitive research, it is increasingly becoming evident that the burden of reproductive ill-health that women have to bear in silence- from the shame of reproductive tract infections to the religious and political dictats against abortions.

This booklet aims to bring to focus some of the more common reproductive health related conditions women have to face up with, including the social dimensions of these morbidities. There are number of experimental and pioneering models of dealing with these situations which have been tried in India and the main considerations that have been kept in mind in these experiments have also been discussed. Finally the booklet provides some examples of these innovative projects and provides an exhaustive list of resource organisations on this issue.

Section One

Understanding Women's Health Problems

Determinants of Women's Health

Women's health has been a largely ignored area for a long time, and it is only recently that some amount of documentation is being done on the subject. The more one learns the more one is convinced how complicated the matter is. It is easy to define health or illness in bio-medical terms and even today most health related professionals are taught how women's health is a matter of nutrition, or perhaps poor hygiene, bad obstetric practices and so on. But a closer look at the situation reveals that this simple explanation is inadequate to explain the myriad of factors which affect each other and in turn affect women's health or lack of it. To understand the factors affecting women's health one has to understand the factors affecting women's lives, for most of the factors that affect their lives, directly and indirectly also affects their health. In this section we will try to explore some of the major determinants of women's health.

Socio-cultural determinants

Gender – Gender roles and power relations within the community determine women's health status to a great extent. This includes the differential food allocation for girls and women, pressure to get daughters married off, differential educational opportunities provided to girls *vis a vis* boys and so on. Violence at home is also of product of gender relations. Women's ability to negotiate contraceptive use with husbands, the ability to negotiate the number of times she has to get pregnant, or the decision to abort a female foetus, all depend upon the power a woman has at home and in the family.

Religion – Religion is one of the main instruments which lays down how the followers should behave. They include strict codes which are enforced on moral behaviours, bodily functions, contraception and so on. Many of these religious codes in many of the worlds religions are detrimental to women health and rights.

Traditions – Traditions are somewhat different from religion in the sense that traditional codes may not be sanctified by religion, but they are equally strong and depend upon the region and local mythologies. Dietary practices and restriction, restrictions on the mobility of women, age at marriage are instances of traditions which have great implications on women's health.

Educational Status – The impact of women's educational status on maternal health and child survival was being studied by demographers in order to understand whether the goal of population stabilisation is easier to achieve with an educated group of mothers. Similarly the health of women themselves is profoundly affected by their level of education.

Bio- Medical determinants

Biology – This is the most important bio-medical determinant in as much that the physical fact of being female makes women susceptible to many health problems. Many (but not all) of these are related to the consequences (including late consequences) of pregnancy and childbirth. Cancers, bleeding disorders and other conditions related to the reproductive tract are typical to women. In fact the discipline of gynaecology in the medical sciences is concerned exclusively to such disorders.

Nutritional status – While this is a bio-medical determinant, it is profoundly affected by the socio-cultural situation as well. The widespread prevalence of anaemia, interpreted in bio-medical terms is due to lack of proper nutrition, and menstruation and repeated childbirths (biology). At the same time the amount and quality of food that a girl-child or woman receives, the times she has to undergo childbirth and abortion are clearly factors which are socially mediated.

Economic Determinants

Poverty – Poverty is a very important determinant of women's health. This is not only the general poverty of the whole family but also the relative poverty of women within the household. Women have much less access to and control over the economic resource and this makes women the poorest of the poor. Poverty affects birth conditions and outcomes, health status in childhood, social status, educational status and so on. Women do most of the housework, which is unpaid. Thus their economic contribution is undermined and when it comes to healthcare worthy action – food, money for medicine, rest and so on, women receive less priority. Sanitation and personal hygiene, two very important determinants of women's health again depend upon the economic situation of the woman. The long and arduous work hours that women have to keep affects women's mental health as well. Economic vulnerability often forces women into accepting situations of violence and unsafe sex.

Environmental degradation and women's health- Environmental degradation is the reality in most of world's poorer nations and also in India. This degradation of the environment is linked with the workload of women, and their work load seriously affects their health. All over the world, and this is also true of India, in economically weaker and rural communities women share the lions share of the domestic workload. Rural lifestyle is heavily dependant on natural resources. Forests provide timber, firewood, leaf-litter and even the supply of water is dependant on the status of these forests. The fields also produce fodder and kindling in addition to the crops. Cow dung is jealously collected as an important source of fuel. And the collection of all these, is primarily the task of women. With increasing deforestation and environmental degradation these resources are getting scarce and so the task for women is getting harder. Even advances farming technology is reducing some of these natural products – for example crop residue, cow dung and this leads to an increased burden on the poor woman to arrange for substitutes.

The increased work load of the poorest women, contributes to a great extent to her health status. Due to the lack of time she often does not have time to look after herself- even in terms of time for bathing and attending to personal hygiene. On the other hand she also has to suffer such conditions as miscarriage, generalised weakness, bodyaches and joint pains, uterine descent and so on. It goes with saying that her nutritional status is also affected.

Violence as a determinant of women's health

It is important to consider the importance of violence as a determinant of women's health. Women are exposed to a continuum of violence right from the time they are conceived. This violence takes place in all spheres of her life- at home, at the work place, in the community and of course in situations of conflict. All these types of violence against women are linked to the same familiar causes : their lower social status, the notion that women are the 'property' of men, and that it is acceptable for men to exercise control over them, by whatever means.

Domestic violence- This kind of violence against women has been called the 'hidden epidemic', because of the widespread nature of its prevalence. But there is a reluctance to take action against such violence when it takes place in the privacy of the home. But the statistics gathered over the last decade or so have brought to light how widespread it is and how profoundly it affects the health of women. Domestic violence includes- battering, rape, sexual abuse, even burning and homicide. The physical and psychological consequences of such violence is serious physical trauma, pelvic pain, miscarriages, burns, attempted suicides, depression and other psychiatric morbidities.

Unfortunately most health systems and health planners at all levels have been slow to respond to this 'hidden epidemic', and do not consider this a health issue at all. Women's health activists in many countries demand that the health sector

- Regard domestic violence as a public health issue
- Undertake more specific research on its causes, consequences and methods to prevent it
- Disseminate information about domestic violence to health workers or conduct training to strengthen their ability to recognise the signs of domestic violence

Violence in displacement and conflict situations- Women are specially vulnerable in situations of armed conflict or mass population movement. Women are forced to leave their homes as refugees and are often separated from the men in their families, and have few means to protect themselves from violence. Armed conflicts use women's bodies as a battlefield in its struggle to appropriate institutional power and is therefore a political phenomenon. Sexual assault against women is seen as a victory over the enemy. Thus all situations of armed conflict leave women vulnerable to sexual exploitation and sexual violence which may lead to physical injury, unwanted pregnancies, RTIs and STIs, and of course the whole range of mental and emotional consequences.

When women have to leave their homes and live the life of refugees, they have to suffer other health consequences as well. There is hardly any privacy for mundane acts like bathing, going to the toilet or for maintaining menstrual hygiene. Pregnancy and childbirth also become extremely high risk in such situations. There are no services for safe abortions and in a nutshell the total health care delivery system is unavailable.

Common Gynaecological morbidities in India

A number of community based studies done in the last ten years have come with a fund of information about the kinds of gynaecological problems women face and their prevalence. The common conditions and their prevalence are summaries in Table 1.

Table 1
Prevalence of self-reported and clinically diagnosed gynaecological morbidities : six community –based studies in India

Women Reporting	Percentage
Self reported conditions	
• Menstrual problem	33 – 65
• Excessive discharge	13 – 57
• Lower abdominal pain	9 – 21
• Lower backache	5 – 39
• Painful intercourse	1 – 7
One or more condition	55 – 84
Clinically diagnosed conditions	
• Vaginitis	4 – 62
• Cervicitis	8 – 48
• Cervical erosion	2 – 46
• Pelvic Inflammatory disease	1 – 24
• Prolapse	<1 – 7
One or more condition	26 – 74

From : Koenig M, Jejeebhoy S et al. 1998, Investigating Women's Gynaecological Problems in India : not just Another KAP Survey. Reproductive Health Matters. Vol 6 No.11(May):84 – 96.

One thing that is immediately clear from this table is that a large proportion of the women either feel they have a problem or they clinically have a problem- and this is as high as 74% or 84 % of the total number of women in the study. Thus the incidence of gynaecological morbidities is very widespread.

Common women's health problems

There are a large number of gynaecological disorders which affect women. In this section we shall look at some of the more common disorders, focussing on how the physical problem is affected and mediated by social, cultural and economic factors.

Reproductive tract infections (RTIs)

What are RTIs - Reproductive tract infections (RTIs) are common diseases with profound social and health consequences for women. As one of the world's most neglected health problems, RTIs are related in important ways to girls and women's basic sexual and reproductive health and to the acceptability of family planning programmes. RTIs include variety of bacterial, viral and protozoal infections of the lower and upper reproductive tracts of both sexes, and most of them are sexually transmitted infections (STIs). Women can be infected not only from sexual intercourse but also from the use of unclean menstrual clothes, insertion of leaves and other material into the vagina to increase a male partner's pleasure, prevent pregnancy, or to induce abortion, and unsafe childbirth or abortion techniques.

Female RTIs originate in the lower reproductive tract, (external genital, vagina and cervix) and in the absence of early treatment they can spread to the upper tract(uterus, fallopian tubes and ovaries). Though spread of RTIs from lower to upper reproductive tract takes place spontaneously but procedures like IUD insertion, abortion, and child birth can cause greater risk because instruments are introduced through the cervix during these procedures.

Why women are more vulnerable to RTIs- Though men also suffer from reproductive health problems but the number and scope of reproductive health risk is far greater for women for a number of reasons. Firstly, they alone are at a risk of complications from pregnancy and childbirth; second they have to bear the burden of using contraceptives and running the risk of suffering from potential side effects and endure the consequences of unsafe abortion; and thirdly due to their biological make up they are more vulnerable to contracting and suffering complications of many sexually transmitted infections. For example the risk of acquiring gonorrhoea from a single coital event in which one partner is infectious is approximately 25% for men and 50% for women. Moreover women suffer more serious long-term consequences from RH problems including all STIs including pelvic inflammatory diseases (PID).

In societies where a belief in male supremacy coexists with restrictive social structures that limit women's economic, social and legal independence, men often maintain strong control over female sexuality. Due to double standards of sexual behavior, sexual coercion and gender discrimination women are frequently powerless either to avoid intercourse with an infected man or to insist that he use a condom or remain monogamous. Both within and outside marriage they can not have any say in their sexual partner's sexual mobility. Can not negotiate condom use and nor ask them to get tested or seek treatment for STIs.

Barriers to seeking treatment for RTIs - The general perception about RTIs in society is that it is dirty, something to be despised and not talked about hence treatment seeking behaviour is largely affected by this social understanding. RTIs are associated with social stigma, taboos and ostracism. Fears of social consequences are reinforced by low self esteem, illiteracy, and the fear of violence from or rejection by their partners and family members. Fear of exposure and embarrassment is a major deterrent to seeking STI treatment. RTIs have an additional element of shame and humiliation for many women because they are considered unclean. The invisibility and taboos surrounding RTIs and the belief that they should be endured, create a culture of silence within families and communities that can severely compromise women's health. In addition the fear that treatment will be very expensive also comes in the way of seeking medical help.

Abortion

What is Abortion - Biologically the ending of pregnancy before the embryo or foetus can survive outside the uterus is called abortion. Abortion can either be induced or spontaneous. Induced abortions can be safe or unsafe depending on who conducts it, how it is done and where it is done. Spontaneous abortions refer to the premature natural ending of a pregnancy. It is often nature's way of screening out unfit foetuses. Spontaneous abortion can be threatened or inevitable, complete or incomplete and missed. One in six pregnancy ends in abortion, 75% of these before 12 weeks.

Far removed from this biological definition abortion is a battleground between women who demand a right over their own bodies and the pro-life and religious establishments who oppose it vigorously. Abortion is also a tool in the hands of patriarchal society to systematically kill the female foetus.

Abortion as a health, social and political issue - The main health problem of women is induced abortion. An unwanted pregnancy for whatever reason is the main factor behind induced abortion. The reasons for the unwanted pregnancy can be many - son preference, contraceptive failure, being unmarried and/or single, sexual coercion or rape, abandonment or an unstable relationship.

In large parts of our country where either people do not have access to contraceptives, or choose not use them, abortion is taken as another form of contraceptive, which is by no means the right choice. For no matter how well or how safely the abortion is performed repeated abortion has inherent risks. Hence it should not be seen as a means of fertility regulation. But at the same time access to safe abortion services remains a responsibility of the state in India. Unfortunately despite being included in the new RCH programme this remains a promise on paper. Women can obtain abortion from Government health care providers provided they are willing to pay for it. Since most abortion seekers would like to maintain privacy and confidentiality, service providers exploit their vulnerability.

Women are often forced into situations where they have to undergo repeated pregnancies despite not wanting to do so. They have to take recourse to abortions secretly, for fear of rebuke from the family. They choose to go to the most easily accessible and confidential services which are often provided by the *dai*, or the ANM. The abortion is induced in

very unsafe ways and she has to bear the health consequences. On another front women are targetted for selective abortions after sex-selection tests are conducted. This practice continues in many parts of north and western India, despite being illegal.

While abortion services are legal in India, they continue to be illegal in many countries of the world. Availability of safe abortion services has remained a demand of women's health activists for a long time. Women are victims of the situation where they need to go in for abortion, but socially, religiously and politically they are considered the perpetrators of a crime. One needs to look no further than our neighbouring countries where abortion is illegal for evidence of this. In Nepal many of the women who are in jail are poor women who were desperate for an abortion.

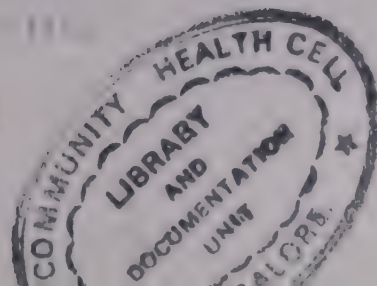
Consequences of unsafe abortion - Maternal morbidity and mortality due to complications of unsafe or illegal abortion constitute a major public health problem. Seventy percent of maternal deaths in developing countries are caused by one of five obstetric complications, of which unsafe abortion is one. Unsafe abortion accounts for about 15% of all maternal deaths. Twenty million unsafe abortions take place each year - 95% of them take place in the developing world. Such illegal abortions are associated with extremely high risks which may result in serious complications or deaths. Complications of unsafe abortions kill at least 7800 women every year. Long or short term disabilities that women experience due to unsafe abortion include severe bleeding, injury to internal organs and infertility, sepsis and poisoning from abortifacient medicines which also lead to renal failure.

Abortion related morbidity and mortality is a matter of great concern to all in India. It is estimated that about 65 lakhs abortions take place every year in India, out of which 25 lakhs are estimated to be spontaneous and 40 lakhs induced. Despite one of the first countries in the world to have legalised abortion (MTP Act on 1971) a large proportion of induced abortions are illegal, induced by unqualified persons and/or women themselves. About 12% of maternal mortality is due to abortion alone.

Infertility

What is infertility - From a medical stand point a couple is considered possibly infertile if they have failed to conceive within one or more years of regular unprotected coitus. A frequently held view is that 75-80% of the couples achieve pregnancy if they want so within one year of regular unprotected sex. Another 10% do so by the end of second year. Hence some 10% or 15% of couples are unable to conceive a child. The incidence of secondary infertility is also very high, which refers to those couples who are unable to have subsequent children. But if you ask a childless woman what infertility means to her, she will not relate to any of these dry statistics, because infertility for her is perhaps the biggest curse, and the cause for most of the misery in her life.

Causes of infertility - There are three main causes of infertility and they are physiological, pathological and social. Among physiological causes infertility is a rule before puberty and after menopause and also during menstruation and pregnancy. Also in early the lactating period conception often does not take place. Pathological causes of infertility are attributed to both men and women. In men causes of infertility are poor



quality of semen (not enough sperm, weak sperm, not enough semen etc) or the inability to deposit semen in the vagina, impotence and premature ejaculation. In women pathological causes of infertility are failure to ovulate, blockage of fallopian tubes due to infection and so on. Lack of knowledge about women's fertile period, and not having opportunities to cohabit during fertile period, or prolonged absence of the male partner are some of the social causes of infertility. Among the reasons of secondary infertility tuberculosis of the uterus, sexually transmitted infections (STIs), malaria, reproductive tract infections are the most common. According to a WHO report in cases of infertility with its serious marital and social consequences, STIs are the attributable cause in 50-80% of affected women.

Different sources have different opinions on the male-female factors responsible for infertility. Whatever the opinion one thing is very clear and that is both man and woman share equal responsibility of infertility contrary to popular social belief where infertility is seen as a 'women's thing' or a 'women's problem'.

Social consequences of infertility for women - Since infertility is seen as a woman's problem women are subjected to many harassments. She is the one who is victimized and abused by society further jeopardizing her already fragile social status. Generally men are never held responsible and often the woman who is ignored, abandoned, divorced or simply thrown out of the house by her in laws. She is not even well received at her natal family. She is called names, she is considered inauspicious, her presence in any social or religious gathering is not allowed.

Some of the other health problems include -

Prolapse of the Uterus - This condition is one of the commoner problems that women have to face and refers to the gradual hanging down of the uterus. The woman feels that something is coming down her birth canal, and it can lead to an uncomfortable feeling, urinary problems and even ulcers on the mouth of the uterus. While advancing age can cause the ligaments which hold the uterus to slacken, there are a number of other factors which often cause women in younger years to also face this problem. Some of these are general debility, giving birth to many children and frequently, pushing down on the abdomen during labour, heavy workload immediately after delivery. It is clear that many of these factors are daily realities for millions of women in our country.

Lower Urinary Tract Pain - This is a very common problem with women from all classes and sections of society. While it is often dismissed as cystitis or UTI, this condition is aggravated and triggered by a large number of factors- many which are beyond the woman's control. While infection of the urinary bladder or the urinary passage (urethra) can be causes for this problem, it is aggravated by situations like - low intake of water (women often drink less water so that they do not have to void too frequently because it is difficult to get privacy for this act), intercourse (an act which is often dictated by the needs of her partner), infections of the lower genital tract (which are often a result of poor hygiene and genital hygiene is difficult to maintain when you do not have toilets or any privacy), trauma during childbirth and so on.

Breast and Cervical Cancers – There are a large number of gynecological malignancies, but breast and cervical cancers are not only the two most common cancers in women, but their prognosis and survival rates are dependant on social and economic conditions. Breast cancer is commoner in developed countries while cervical cancers are commoner in our country. The survival rates from both these cancers are pretty healthy if they are detected and treated early. This is facilitated not only by increased personal awareness of the condition but adequate medical facilities for detection and care. Breast cancers are easily detected as lumps during personal breast examination and regular physical examination and mammography gives an advantage for survival. Cervical cancer on the other hand not only has a preference for poorer women with early childbirth, too many or too frequent births and poor genital hygiene. Early detection is impossible because the facility for screening is not available and its symptoms (irregular vaginal bleeding, vaginal discharge,) are often ignored.

Women's Health in later years

Menopause

Menopause is not a problem, but just like menstruation it is seen as one in many places and here we will discuss some of the important issues related to it. Though menstruation has gained some importance in research worldwide, but menopause still remains a less understood topic.

What is menopause - Menopause means the permanent cessation of menstruation at the end of reproductive life. This is a gradual biological process occurring between the ages of 45-55 years. This happens because of decreased secretion of female hormones (oestrogen and progesterone). This interferes with ovarian function, resulting in inhibition of ovulation and menstrual flow. Side by side there are atrophic changes in the ovaries, fallopian tubes, uterus, vagina, vulva, breast, bladder and urethra.

Menopause and Health- The experiential definition of menopause is not exactly the same as what the medical paradigm offers. The experience of each woman depends on variables such as her age, cultural background, health, type of menopause (natural or surgical), desire for more children and so on. Many women view menopause as a signal of major change in their lives either positive change such as freedom from the need for contraception, or negative change such as experiencing mood swings or feeling "old". In some Asian cultures where women reach menopause without much notice at all some might be sad that their reproductive years are over and still others might be happy to find her headaches have resolved. Menopause is just one point in the continuum of life and health status at this time is largely determined by prior health status, reproductive patterns, life style and environmental factors. Besides this culture also plays a significant role in women's menopausal experiences.

In a majority of women apart from cessation of menstruation no other symptoms are evident. But in some secondary symptoms like hot flashes, (profuse sweating for 1-2 minutes usually at nights) vaginitis, endometritis, anxiety, headache, insomnia, irritability and depression can occur. Feminists say that these changes are incorrectly attributed to

menopause. Research increasingly shows that women are no more likely to be depressed at mid-life than at any other time.

Box – Treatment of menopausal problems

Treatment of menopause related problems can be done in two ways, non-hormonal and hormonal. In non-hormonal treatment better nutritious diet, exercise and supply of extra calcium in diet are supposed to be helpful. Hormone replacement therapy (HRT) is known as the practice of prescribing oestrogen and progesterone containing drugs to replace the amounts of these hormones no longer being supplied by the ovaries during and after menopause. One has to be cautious about using HRT. Despite certain benefits like treatment of hot flashes, treatment of symptoms of vaginal atrophy and prevention of osteoporosis, there are many more side effects of HRT treatment. The most common side effects are breast tenderness and fluid retention. Secondary level of side effects of oestrogen are secretions, skin rashes, hair loss, hair growth on the body, pigmentation, intolerance to contact lenses, vaginal spotting or bleeding. Side effects which are reported after progesterone use are breast tenderness, abdominal bloating, ache and depression.

Health Concerns of the elderly

Advancing years lead to many changes in the lives of women, especially in India. Their roles change from the person who has to obey many masters – both human and ritual, she slowly emerges relatively independent who now defines many of the rules. There is reduction in physical workload, but there can also be a sense of vulnerability especially if she is a widow. At the same time the process of ageing also affects many of the vital functions of her body. The health of the elderly woman is the result of the interaction of many such physical and social factors.

Some of the major health problems that elderly women have to face are described below. As a result of biology the bones of the body start weakening in women soon after menopause, poverty contributes to the process when she cannot afford enough calcium to slow this process. Elderly women easily become victims of fractures and these don't heal easily. The weight bearing joints like the knees and the lower backs, which have borne years of high stress fall prey to arthritis. The respiratory tract, which in rural women faces up to the smoky wood-fires day in and day out start losing their vital capacities. Eyes fall victim to the natural process of ageing and develop cataracts. Hearing is gradually impaired, and mental faculties start slowing down. Emotional and behavioral problems also crop up in many cases.

That elderly develop health problems is not the only cause for concern, but whether there are adequate provisions both within her family and society to take note of these and provide her with support. As women grow older they slowly lose some of their autonomy and need to be cared after more actively. Their physical and emotional needs change. The family has to be sensitive to when she needs active medical help. With progressive nuclearisation of families even in rural India, elderly women are losing out on family support which was earlier accessible.

Section 2

Important issues for operationalising women's health

Role of traditional and home remedies in Women's health

There has been an increasing trend among voluntary organisations to adopt traditional herbal and home remedies as integral part of women's health. This has even led to the Government of India giving space to what it calls the Indian Systems Medicines in the Reproductive and Child Health programme.

There are a number of reasons given by votaries in favour of traditional and home remedies. One reason given for integrating these is that they are more holistic than modern medicine, which tends to treat individuals in isolation. Traditional methods include physical, social and spiritual aspects and also integrate life-style and diet with therapy. The second argument given is the issue of accessibility. In many cases modern medicine is not available. If the drugs are available, a reliable therapeutician is not. Home remedies as the name implies is available at home and many traditional remedies utilise local fauna and so can be easily available. Other herbs can be grown in the garden. The financial aspect too comes into comparison and local remedies are more often than not cheaper. Another reason in favour of herbal and home remedies is that there are therapies available for a large number of the complaints that women have and many of them are effective. While these therapies may be different in different places, multi-centre studies done in the last few years have proven that they work. Finally traditional and home remedies builds upon women's existing knowledge and experiences. Many women have known their use as children or even as adults, and modern medicine has made inroads into their consciousness only lately. While modern medicine does come with its magic of instantaneous cures through injections, traditional and home remedies are part of their heritage. Many of the changes that have taken place in lifestyles have led to the devaluation of women's knowledge, and reinforcing effective traditional and home remedies is seen as a means giving women's knowledge value.

There are of course certain limitations and debates on the use of traditional and home remedies, and many of the organisations promoting these themselves realise. Traditional systems of medicines is not one system and includes some formal systems (ayurveda, unnani, tibetan, siddha etc.) and even informal systems (exorcism, faith healing, etc.) are also considered part of it. The therapies promoted must be tested for efficacy. It is often a thumb rule to consider all therapies which appear in classical texts as tested. On the other hand many of the votaries of these therapies agree to testing but disagree on the methods advocated by western science. There was a large multi-centric study done by women's groups to test out the efficacy of traditional and home remedies (Shodhini study), but the methodology was widely different from classical clinical trials. The second reservation is about the universal applicability of traditions. It is widely known that many traditional practices are harmful, thus the practitioners and promoters must be very careful about which praactice they promote and which they do not. When it comes to traditional practices the line dividing practices and therapy can often be a very thin one. A third

reservation about traditional systems is that traditional systems are situated in a specific cultural context and as has been discussed earlier, the position of women in the traditional cultural context is against the interests of her health and rights. Thus this angle needs to be critically explored by the women's health practitioner. Overall the opinion is that traditional and home remedies have a definite role in improving the status of women's health, but it needs to be promoted only after the group has fully understood the different socio-cultural determinants of women's health.

Women's access to health care

Access to health care is related to all those concerns and conditions which determine to degree to which an individual or group is able to obtain the needed health care services. This access has to be timely and one which allows the individual or group to achieve the best possible health outcome. Access is also affected by attitudes to health and health care, gender and social and cultural factors. If one considers the access women have to health care services, one will have to consider a number of factors. These include factors which are present in herself and her family which determine whether she will be able to go to a health service. Then there is the condition of the health service and how it provides her with care.

Women possess a very low sense of self worth and thus are reluctant to pay great heed to their complaints, especially if they feel they will also need to bother others. Going to seek health care is also an economic decision both in terms of the money it costs and work-time lost. The distance to the health care provider, the sex of the provider, attitude towards the provider also determine whether she will be able to go and visit her/him. Once the woman actually goes and meets the health care provider, there comes in the entire question of how competent the provider is in understanding her problem and dealing with it. The atmosphere in most clinics and hospitals hardly provide women with a sense of security, privacy and concern. Even the most qualified women doctors are often unable to understand the problem of women, beside arriving at clinical diagnoses. In such a situation it is not possible for her to get the best possible outcome. And anyway the health care provider most women meet are far from being the most qualified. The kind of service delivery environment that is best suited to women's health needs have already been described in the first booklet on women's health.

Understanding the Language of Women

Where it is culturally inappropriate for women to discuss problems of the reproductive system, where women have been socialised to think that their reproductive organs are dirty and polluted, and where women have to suffer and live with their different reproductive health problems in silence, they develop new ways of dealing and expressing their problems. For the health worker it is important to understand this language. Where functions and problems of the reproductive tract are concerned, women have a reluctance to discuss details with some one else, a phenomenon so widespread that it is referred to as the 'culture of silence'.

The present structure and functioning of the health system does not provide women an enabling environment and privacy to facilitate positive health seeking behaviour for problems of the reproductive tract, especially those which are sexually transmitted infections. This leads to delayed identification, misery, pain, and further complications. Women are known to accept vaginal discharge, itching, menstrual discomforts, ulcers, discomfort during intercourse, or even chronic pelvic pain, painful urination etc. which accompany some reproductive disorders as an inevitable part of their womanhood, something to be endured along with other reproductive health problems. In some situations women can complain of vague aches and pains, or weakness when her real problem is elsewhere. Women also tend to refer to their problems obliquely, and it is only after patient questioning that the real nature of their problem becomes evident.

Persons trained in health care often tend to think in terms of diseases and their possible causation. Women on the other hand refer to their disorders as illnesses, symptoms and problems. They have their own system of understanding causation which often involves a complex interaction of social customs and beliefs, religious transgressions, what they think is health related behaviour. In order to understand the problems of the woman the person also needs to be culturally attuned. For the sensitive health care provider it is a challenge to understand the real problem or the individual, because it is only after this is understood that healing can begin.

Women health care givers

The importance of having lady doctors for women is best illustrated in states like Uttar Pradesh where district hospitals are bifurcated into creating special Janana (women's) hospitals. The local cultural traditions in north and central India make it difficult for women to seek help from male practitioners, and male practitioners often have to diagnose gynaecological disorders by examining the radial (wrist) pulse. Lady doctors are often absent from rural health centres and even Auxiliary Nurse Midwives (ANMs) the backbone of the community based public health system in India is known to play truant. In such a situation even women who would like to show a health care provider have very little options. As an alternative many community based projects run by voluntary organisations have been systematically training local women as health care providers of women. The women, in many cases traditional birth attendants are being trained in basics of anatomy and physiology and then taught the use of herbal or in some cases modern medicines.

The important question that needs to be asked is that if there are women doctors and nurses present can we assume quality health care for women. Unfortunately the sex of the health care provider does not automatically ensure this. With a woman care-giver the chances of a gynaecological examination are higher but the chances of better care are not assured only because of this. Medical science is extremely patriarchal in its perception of women and their health problems. Women health care providers trained in this system naturally assimilate this and we have situations where the women health care provider act violently with women in labour, berate them for their illnesses, scold them for coming after it is too late. In such a situation the trauma of going through the health care delivery

system may be more severe than the illness. What is important even for women health care providers is to considerate, patient and sympathetic to the client and this is only possible if the provider understands the situation from which the woman is coming from and the complex social factors which have influenced her problems. Even while training local women as health care providers it is important that they understand these determinants. While it is easier rural women to understand these, as they also operate in their own lives, generations old empathy for women that traditional birth attendants (dais) had, are known to have been replaced overnight through single training events in hospitals.

Women healers are not uncommon in rural India. Though they may not command the respect that *vaid*s do, these women are an important resource for other women in the community. Very often it is the traditional birth attendant (dai) who is also the healer and many of them have a fund of knowledge about gynaecological problems. Strengthening these healers through additional training in new skills and perspective is one way many voluntary organisations are trying to provide health care services to women who need it.

Empowering women for health

Women's health is one aspect of women's lives over which they have little or no control. In order to help women exercise greater control over their lives and movement toward empowering women for health has been started in many parts of our country by different organisations. Two of the key features of this approach is described below.

Self help – This belief stems from the realisation that women have been dispossessed of a lot of knowledge about their own bodies, both by society and by the medical profession. The goals of self help are to put information and control in the hands of women, developing a health care system that meets women's needs and makes the services available to women. Teaching women about their bodies and its processes and the use of home and herbal remedies are two cornerstones of this approach. This not only allows to understand the bodies and its problems better, but they are in a better position to obtain appropriate health care earlier and at their own terms.

Advocacy for health – Knowledge about the body and herbal remedies for simple complaints are a great step towards women gaining control over their own health, but is not the final step in this direction. Women will continue to need the public health care system to meet other health needs. Unfortunately this system is at best unable to deliver many of services required by women. Keeping this reality in mind women in many parts of the country have organised themselves into groups and are demanding better treatment and services from the public system.

Section Three

Working on Women's Health

Different approaches of working on Women's Health

Working with women and their health has for long been one of the main areas of activity for NGOs. Over the years many organisations shifted shifted their focus from a strictly maternal and child health orientation, to gradually include other aspects of women's health. NGOs were among the first to draw attention to serious problem of reproductive tract infections that women suffer in silence. Over the last ten years of so NGOs have tried a number of novel experiments all over the country which are addressed towards assisting women achieve a better health status. Dealing with reproductive tract infections has been one of the key element in most of these experiments. Some of the common approaches are described below.

Clinic based approach – This approach is being tried out at a small number of projects where the special clinics are being operated for treating women with RTIs. The work at the clinic are supported by community based health education for awareness raising and for referral of symptomatic cases.

Community based approach – This is the more prevalent approach where the programme includes community based health education, training of paramedical workers in health education and primary treatment either through herbal medicines or using modern medicines. The strength of the community based approach lies in mobilising women in communities to realise their own situation and taking steps towards changing it the process of change is very slow, but there are enough evidences to show that it is possible. Once women learn to accept their own bodies and its processes as natural and something not to be ashamed of, they show a keenness to learn more about it and take active measures to keep healthy. Once women are willing to learn more, many take up the challenge of learning herbal remedies, grow and make medicines, actively engage with others in the community for changing their attitudes and so on.

Clinic –cum community based approach – In this third approach the community based approach is strengthened by an organisational referral system, but this is only possible where the organisation has an in-house or on-call gynaecologist. Often the gynaecologist is asked to come on a camp basis and community based workers are involved in screening and selecting cases for the gynaecologists visit.

Strategies for change

The different organisations that are involved in working in the area of women and health have all adopted different strategies for enabling women access better services and gather more control over their their health. Some of these strategies are as follows:

Organising women- Almost all the organisations that are working on the issue of women's health have organised the women in the communities into groups or mandals. These groups are an important fora for health education, discussing new ideas with women and beginning the process of new learning. These women's groups are also an important vehicle for facilitating change in attitudes and behaviour. When women learn new things about themselves and start challenging some of their most strongly held notions the group of peers provides a secure atmosphere for making these experiments.

Raising awareness about the body and its processes- This forms one of the core strategies for change. Different organisations have used different methods –modular courses, informal camps, regular meetings, self examination and so on, for raising women's awareness of their own bodies and its functions. From early childhood women develop very negative feelings about their bodies and these efforts allow women to start knowing and appreciating their bodies for the first time. Once this has begun women are willing to be more assertive to keep their bodies in good health.

Building local capacities – This involves the training of local women in different aspects of women's health with which they not only help themselves but other sisters in the community. This has been to the extent that in some projects local women are now competent in the use of speculum for gynaecological examinations. In some places traditional birth attendants (dais) skills have been upgraded, in other places young people have been trained as health workers. The focus is that the women in the community should obtain some degree of self sufficiency in dealing with their own problems, before they need to visit a doctor.

Use of herbal and traditional medicine- This aspect has been discussed in detail earlier.

Training for women's health

One of the main challenges in implementing a woman's health programme which takes into account women's health needs, their vulnerabilities, social realities, is to develop a training strategy which will enable the training and reorientation of different members of the team who will take up this work. This includes training of managers field workers as well as the community. Most learning experiences are usually through very hierarchical models where there are teachers and learners, with a strict hierarchy of knowledge and power. If one has to slowly build the confidence of women to learn to accept their bodies and to start a process of questioning many of her previously held notions, the facilitators role is very different from that of a teacher. And this facilitation has to be done by the field worker and the manager as well as the nurse and the doctor. Thus these workers also need to go through training programmes which allows them to develop a degree of sensitiveness and empathy towards the women's situation. Even for technical trained persons like doctors, it may involve developing new skills in communicating with women. Different experiments have already started in developing training modules for middle level managers, field workers as well as doctors and nurses in equipping them to deliver more sensitive and need-based services to women.

Some innovative community based women's health programmes

There are a large number of organisations involved in innovative work on women's health. Brief outlines of the work done by four organisations is being given here. A more comprehensive list of organisations working on women's health is provided in the Resource Section.

AIKYA – AIKYA has been at the forefront of using and documenting the use of herbal remedies for women's gynaecological problems. They have been a partner in a country wide documentation exercise through the Shodhini network and since then have been actively involved in training women healers in the use of herbal remedies. At the community level they are involved in organising village level health groups 'arogya sanghas'. Women are also encouraged to learn how to heal themselves by making remedies on their own.

MASUM- MASUM is a rural women's collective based in Pune. Its goal in addressing the sexual concerns of women is to get women to fight for their rights at all levels rather than negotiate at the last resort. The major reproductive health intervention of MASUM has been the running of afeminist health centre *Streevadi Aarogyakendra*. The centre is staffed by a consulting gynaecologist, a full time nurse and a visiting health worker. The centre provides clinical facilities and follow up services. Through its health education the staff is committed to spread the idea of rational drug therapy. Exercise and quality of life are stressed more than pills in this programme

RUWSEC – RUWSEC has been one of the pioneering organisations in developing interventions in the area of women's health. The organisation works in the Chingleput district of Tamil Nadu. Today they have a very comprehensive women's health programme which integrates women's health with women's education and women's development. They train village health workers in providing first level of care and health education, while a referral clinic provides second level of care. The services provided include MTP, surgery, gynaecological clinic, screening for STIs and so on.

SEARCH – SEARCH is an organisation which works with the tribals in the Gadchiroli district of Maharashtra. This organisation has been one of the first in the world to draw attention to the burden of reproductive morbidities that are faced by rural women. Their Reproductive Health programme includes four components – participatory research, mass education in sexual and reproductive health issues, community based reproductive health care and referral services. Dais, arogyadoots and ANMs are trained to common gynecological problems and also advise referrals.

Addresses of all these organisations are provided in the Resource Section

RESOURCE SECTION

Further Reading

- Andina, M. et.al. 1998. Trust : An Approach to Women's Empowerment. Los Angeles: Pacific Institute for Women's Health.
- Bajpai, S. 1996. Her Healing Heritage. Ahmedabad: CHETNA.
- Berer, M. 1989. Living Without Children. United Kingdom: Blackwell Sciences.
- Berer, M. 1998. Women's Health Services : Where are They Going. United Kingdom: Blackwell Sciences Ltd.
- CHETNA. 1996. WAH- Curriculum Revision and Development. Ahmedabad: CHETNA.
- Dixon- Mueller, R. et.al. 1991. The Culture of Silence. New York: International Women's Health Coalition.
- Dutta, D.C. 1994. Text Book of Gynaecology. Calcutta: New Central Book Agency.
- Germain, A. et.al. 1992. Reproductive Tract Infections. New York: Plenum Press.
- Gopalan, C. and S.Kaur. 1989. Women and Nutrition in India. New Delhi: Nutrition Foundation of India.
- International Institute for Population Sciences. 1996. Selected Readings on Reproductive Health. Mumbai: International Institute for Population Sciences.
- Jacobson, J. 1991. Women's Reproductive Health: The Silent Emergency. Washington: World Watch Institute.
- Joseph, A. 1996. Maternal Mortality and Morbidity, Bangalore.
- Khanna, R. 1992. Taking Charge: Women's Health Empowerment. Vadodara: Sahaj.
- Lemcke, D.P. et.al. Primary Care of Women. Norwalk: Appleton and Lange.
- Llewellyn-Jones, D. 1993. Every Woman. New Delhi: Penguin Books.
- Mukhopadhyay, A. 1998. Prevent Unsafe Abortion. New Delhi: VHA.
- O'Sullivan, S. 1987. Women's Health: A Spare Rib Reader. London: Pandora Press.
- Padubidri, V.G. et.al. 1994. Shaw's Textbook of Gynaecology. New Delhi: B.J. Churchill Livingstone.
- SHODHINI. 1997. Touch Me Touch Me Not. New Delhi: Kali for Women.
- Stein, K. et.al. 1998. Critical Issues in Reproductive Health: Abortion Expanding Access to Safe Abortion Strategies for Action. New York: International Women's Health Coalition.
- VHA. 1993. Women and Health: Gynaecological Disorders. New Delhi: VHA.
- VHA. 1999. Infertility. New Delhi: VHA.
- VHA. 1999. Menopause. New Delhi: VHA.
- Women's Health Action Foundation. 1995. A Healthy Balance. Amsterdam: Women's Health Action Foundation.

Resource Organisations

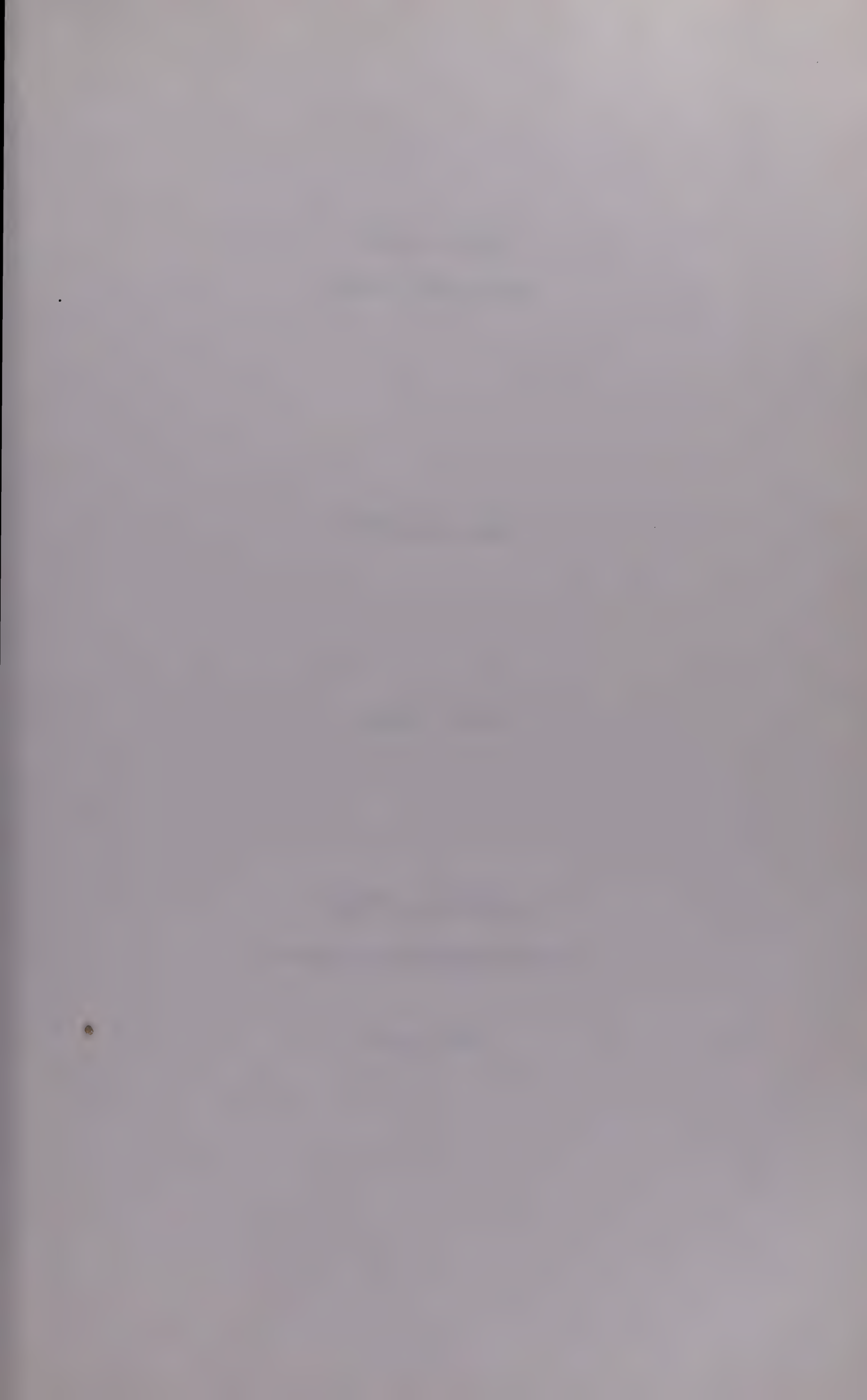
There are a large number of organisations working on Women's Health either as a grassroots implementing agency or a support organisation. Addresses of some of these are being provided here.

Action India	5/24 Jangpura B
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Community based project ,Herbal, Material preparation	New Delhi 110 014 Phone 011-6467470
ARCH Community based project, Research	P O Mangrol, Taluka Rajpipala Distt. Bharuch 393 150(Gujarat) Phone 02460-40140, 40154
Aikya Community based project, Training, Herbal	377 Jayanagar, 42nd Cross Road, 8th block Bangalore 560 082(Karnataka) Phone 080-6645930, 8432363 Fax 080 6631564 attn. Aikya
BMC Innovation with the government system	1st Floor, BMC Office Building, Nehru Road, Vile Parle(E) Mumbai 400 057 (Maharashtra) Phone 022-6162436
CHETNA Research, Material preparation, Training	Lilavatiben Lalbhai's Bungalow, Civil Camp Road, Shahibaug, Ahmedabad-380 004 (Gujarat) Phone : (079) 786 8856, 786 5636 Email: chetna@adinet.ernet.in
CINI Research, Community based project, Training, Material preparation	P.B. No. 16742 Calcutta 700 027(West Bengal) Email- cini@cal2.vsnl.net.in
Deccan Development Society Research, Herbal, Community based project	A-6 Meera Apartments Basheerbagh Hyderabad-500 029 (A.P.) Phone 040-231360, 232867 Fax 040-231260
IWID Training	Sabla and Kranti A/201 Vasant View D'monte Lane Malad (W) Mumbai 400 064 Phone & Fax- 022-8886237 E-mail - kranti@bom5.vsnl.net.in
MASUM Community based project, Research, Training	11 Archana Apartments 3rd Floor, 163 Sholapur Road, Hadapsar Pune- 411 028(Maharashtra) Phone- 0212-675058 Fax- 0212-611749 E-mail- admin@masum.ilbom.ernet.in
RUSWEC Research, Community based project	Plot No. 12, Peria Melamaivur Village road Vallam Post, Chengalpattu-603 002(T.N.) Phone 04114-30682
SAHAJ Action research	1 Tejas Aparts. 53 Haribhakti Colony Old Padra Road Baroda-390 015 (Gujarat) E-mail sahaj.locost@sm1.sprintrpg.ems.vsnl.net.in

SAHAYOG Community based project, Training, Research, Material preparation	Premkuti, Pokharkhali Almora 263 601(U.P.) Phone 05962-33029, 32919 Fax 05962-33029, 32919 E-mail- sahayog@vsnl.com
SEWA Community based project, Training, Material preparation	Opposite Victoria Garden Ellis Bridge, Bhadra Ahmedabad-380 001 (Gujarat) Phone 079-5506477 Fax 079-5506446
SARTHI Community based project, Herbal	P.O. Godhar West, Santrampur Taluka Via Lunawada, Panchamahar-389 230 Gujarat Phone 0265-340223, Fax 0265-330430 a/c 88, attn. Locost E-mail- sahaj.locost@sm1.sprintrpg.ems.vsnl.net.in
SUTRA Community based project, Training, Material preparation	Jagjit Nagar via Jubbar Solan 173 225 (H.P.) Phone 01793- 8725, 8734
VGKK Community based project, Government	B.R. Hills 571441 Yalendur Taluk Mysore District (Karnataka) Ph 08226-84025 Fax 08226-84004
WAH Training	Mira Sadgopal Renuprakash-A/3rd Floor 817 Sadashiv Peth Pune-411 030 (Maharashtra) Phone 0212-470314 Fax 0212-476451

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**Understanding
Reproductive Health**

A Resource Pack

Booklet – Seven

**CONTRACEPTION
Going beyond Family Planning**

SAHAYOG

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INTRODUCTION

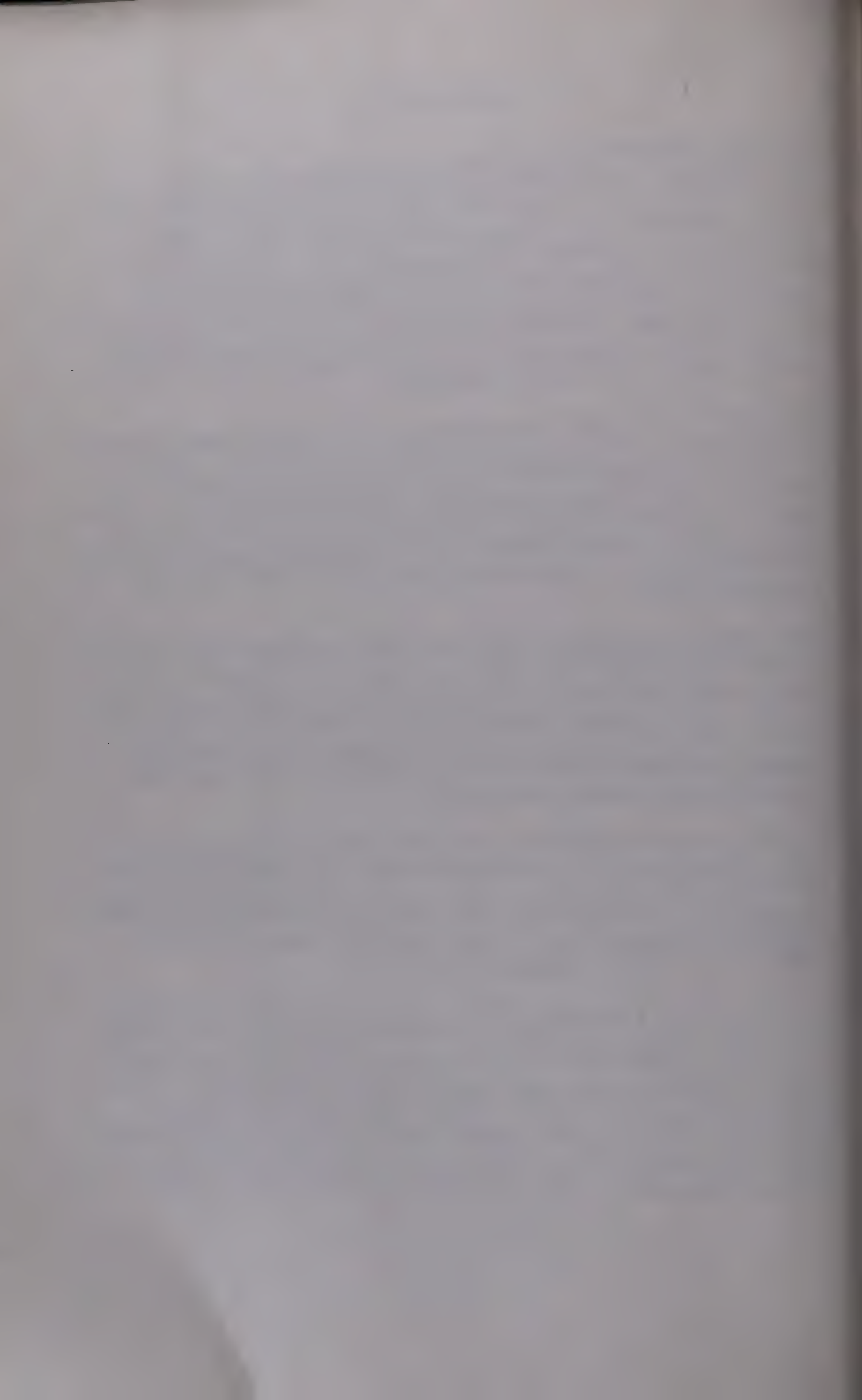
Unprotected sexual intercourse on the fertile days of a woman's menstrual cycle can result in pregnancy. From time immemorial, there have been attempts to de-link sexual activity from reproduction. Various methods have been used in different cultural contexts. Traditional methods of regulating births included periodic abstinence from sexual intercourse at certain festivals, during particular seasons, or after the birth of a child (post-partum). Prolonged breast feeding, and social disapproval of sex after a certain age also contributed to lowering birth rates. Other methods have also been used like 'coitus interruptus', and similar sexual practices which involve ejaculating outside the vagina. Herbal pessaries in the vagina, vinegar douches and an equivalent of the modern condom are also known to have been used.

Contraception or birth-control refers to the range of methods used by women and men to prevent pregnancy. Every year several million dollars worth of research continues to look for the ideal methods for contraception, and several options are available for men and women today. Contraception is often called "family planning", particularly so in our country. The government through its "family planning programme" targets only married couples within conventionally defined families. This leaves out a large number of people who are sexually active, and potential users of contraceptives outside the ambit of government concern.

While contraception is a very personal decision which should ideally be taken together by the woman and man concerned, it has become a matter of public discussion in many countries where there is concern about population growth. If the growth is seen as being too rapid, couples are urged to contracept when the state desires them to do so, such as after one or two children (China, India). Where the population is not growing fast enough to even replace itself (as in West Europe for example), there is a pressure on women to have more children than they desire!

The ICPD resolution specifically says "all couples and individuals (have the right) to decide freely and responsibly the number and spacing of their children, and to have the information , education and means to do so; and to make decisions concerning reproduction free of discrimination, coercion and violence." (ICPD Principle 8, 7.3, 1994) Despite this, the mindset of 'choice' has not been widely internalised, and pressures continue from governments, religious leaders and donors.

Since the outcome of a pregnancy is borne by a woman, it is important that women are able to make contraceptive decisions as and when they want. Control over one's body and the right to regulate fertility has been a cornerstone of the women's movement the world over. However, given the gender disparities that exist, women are often unable to negotiate contraception with their male partners. State control over fertility in many countries (like India) ensures that women have little space within which to negotiate their rights over their bodies. Moreover, the types of contraceptives available/ being researched might not be those with which women really feel comfortable or safe .



In this booklet we will try to get acquainted with the various methods of contraception available for both men and women and look at their respective advantages and disadvantages. We will also look at the current issues and debates in India around contraception.

Section One

Contraceptive Options

What is contraception

Contraception is a deliberate attempt to avoid pregnancy. Pregnancy occurs when the egg meets the sperm, and the zygote (the product of the sperm and egg meeting), attaches itself to the lining of the uterus and starts growing. Keeping this process in mind there are basically five ways to avoid getting pregnant:

- A. The most obvious method is to **avoid having sexual intercourse**, i.e. abstinence from any penis-to-vagina contact. A refinement of this method is to avoid penis-to-vagina contact during the fertile days of the woman's cycle. (Rhythm Method, Fertility Awareness Method).
- B. Another simple method is to **prevent the egg from meeting with the sperm**. This includes the various Barrier methods (Male and Female Condoms, Diaphragm and Cervical Cap) and the permanent methods - Vasectomy (male sterilisation) and tubal ligation (female sterilisation).
- C. A third way is to **prevent the woman from producing eggs and/or the man from producing sperms**. Examples of this include the Hormonal Methods such as Oral Contraceptive Pills, Injectables and Implants under the skin. The anti-fertility vaccines being developed for men and women would also fall into this category.
- D. In yet another approach the **fertilized egg (zygote) can be prevented from implanting** (attaching) itself to the uterine wall. Examples include Intra Uterine Devices (IUDs) and Non-steroidal Pills
- E. The fifth way involves the **removing of the embryo even after conception** and implantation have taken place. Examples include induced abortion and abortifacient pills.

Thus, different contraceptives work in different ways to prevent pregnancy and each person should choose a method that suits her or his requirements, without posing any danger to her/his health and lives. Furthermore, this is not a decision one can make for one's entire life. As one ages or as the nature of one's sex life changes, one's contraceptive needs change.

Box - Factors to be kept in mind when choosing an appropriate contraceptive

The following factors should be borne in mind while choosing a contraceptive:

- the **effectiveness** i.e. what are the chances of getting pregnant
- is the contraceptive **safe**, or are there any serious **side-effects**
- does it have any **long-term adverse effects**?
- Will it affect **breast-feeding**? Will the effect of the contraceptive be passed on in breast milk?
- will it affect the health of **future children** the woman may bear?
- whether it gives **protection from HIV** and other STDs
- is the contraceptive method **reversible**, in case pregnancy is desired

- whether the **male** partner is willing to take an active role in contraception
- whether the contraceptive has special **contraindications** for e.g. not to be used by women with irregular bleeding, or those with reproductive tract infections
- whether **control** over the contraceptive is in the hands of the user, or is it dependent on the health service provider?(end box)

Efficacy of Contraceptives

Each contraceptive method has a different efficacy i.e. how effective it is in preventing pregnancy. Effectiveness is measured according to a theoretical effectiveness rate, as well as the effectiveness in real life conditions. For instance, the oral contraceptive pill has a very high theoretical effectiveness, but if the woman forgets to take even a few pills, the effectiveness gets drastically reduced. The following table will help to get a comparative idea of the effectiveness of different contraceptive methods:

Contraceptive Efficacy of Different methods

Pregnancies per 100 Women in First 12 months of Use

Method	As commonly used	Used correctly and consistently
Norplant Implants	0.1	0.1
Vasectomy	0.15	0.1
DMPA and Net En Injectables	0.3	0.3
Female Sterilisation	0.5	0.5
IUD (Copper T)	0.8	0.6
Breast Feeding (for first 6 months)	2	0.5
Combined oral pills	6-8	0.1
Condoms	14	3
Diaphragm with spermicide	20	6
Fertility Awareness	20	6
Female Condoms	21	1-9
Spermicides	26	6
No method	85	85

Source: The Essentials of Contraceptive Technology – A Handbook for Clinic Staff, John Hopkins Population Information Program, 1997

Brief Description of Different Contraceptives

A. Natural methods (Avoiding genital- to- genital contact, especially during fertile days)

The safest and easiest way to do prevent this would of course be by not having sex at all! The next best way would be to avoid genital-to-genital contact, which can still be a

pleasurable experience. For ages, women have known that it is possible to get pregnant only on a few days of the month. So, they have known that if sexual intercourse is avoided on those days, they can avoid getting pregnant. Today the following methods are available to avoid pregnancy without the use of any artificial means of birth control.

1. The Rhythm (Calendar) method

According to this method a woman is considered fertile after 10 days of the start of the menstrual cycle, hence sexual intercourse is avoided during these 10 days. The 'safe period' thus is considered to be the week during, before and after menstruation. This is an unreliable method because it does not take into account variations in the menstrual cycle. The Rhythm method assumes that all women have 28-day cycles, and that ovulation occurs in the middle of the month. However, each individual woman has a different cycle length, and ovulation may take place at different times. There is also a variation for the woman herself – due to various factors, such as age, stress, following childbirth etc. a woman's cycle length varies. At best, using the Rhythm method may slightly reduce the probability of getting pregnant. It is only slightly better than using no method at all.

2. Cervical Mucus/Billings Ovulation Method

Many women notice that they have some amount secretion (mucus) from the vagina most times of the month. This is a perfectly healthy sign. The mucus varies in quantity, consistency and colour. Sometimes, there may be very little mucus, and at other times there may quite a lot of it. It may be sticky and whitish at times, and at other times it may be slippery and transparent. The nature of this mucus varies with the stage of the menstrual cycle. Soon after menstruation, the mucus is usually scanty, relatively dry, thick, flaky and whitish. As an egg begins to ripen in one of the ovaries, the hormone estrogen circulating in the body makes the mucus transparent, stretchy and slippery. The slipperiness and stretchiness is the maximum during ovulation and a day or so after. Thus, the slippery and stretchy kind of vaginal mucus is a woman's most useful and obvious sign of her fertile days. She can thus choose to avoid genital to genital contact on her fertile days, or use a barrier method such as the condom or diaphragm, in order to avoid pregnancy.

3. Basal Body Temperature (BBT)

A woman can also note her body temperature at the same time early every morning. The temperature of the body soon after sleep is called the Basal Body Temperature. Towards the middle of the month, immediately after ovulation this temperature will rise significantly (about 1-2 degrees Fahrenheit) and stay that way until the next period. If this method is used exclusively, it necessitates avoidance of genital-to-genital contact in the entire period before the temperature rise, i.e. a period of about 1-16 days. Once ovulation has taken place, another 1-2 days are considered fertile. Thus, days on which sexual intercourse is "safe" are relatively few. In addition, the daily trouble of taking the temperature makes the method a cumbersome one.

4. Sympto-thermal method

It is a natural method by which a woman can become aware of the changes that her body undergoes every month, so that she can recognise the time of the month when she is most

fertile. In addition to changes in cervical mucus and BBT, a woman should look for changes in the following symptoms. She can tell that ovulation has occurred by noticing sharp pain in the lower abdomen, tenderness or fullness of the breasts, or by touching and observing changes in the height and softness of the cervix.

5. Fertility Awareness Method

Fertility Awareness is a method by which a woman can become aware of the cyclical changes her body undergoes every month. There are several signs in a woman's body which she can learn to recognise – cervical mucus, basal body temperature, changes in her cervix, breast tenderness etc. A combination of these signs can help her recognise the period when she is most fertile, and use this knowledge to either avoid or achieve pregnancy. A woman can determine her fertile and infertile days by noticing the changes in the character of the cervical mucus by testing some of it on her fingers at about the same time everyday. The mucus is usually found at the vaginal opening itself. With training in Fertility Awareness (from a person who has used the method, or has trained other women in F.A), and some amount of practice, a woman can determine her fertile days with a fair amount of accuracy. The FA method needs special caution if:

- a woman has a reproductive tract infection which may cause changes in the mucus pattern. However, a woman can recognise mucus due to an infection since it is usually profuse, discoloured, foul smelling, or accompanied by itching, pain or discomfort. Practising the FA method, in fact helps a woman to detect infection very early on, since she can recognise the early changes in her mucus pattern.
- A woman is breast-feeding. Ovulation is delayed for some time after childbirth. The period of lactational amenorrhoea (absence of menstruation during breast-feeding) depends on whether there is complete breast-feeding, the nutritional status of the woman, and other factors. However, ovulation occurs before the first menstruation. The FA method, if practiced with care, can help to recognise the changes in mucus which herald ovulation, and hence fertility. However, this requires training and practice.
- A woman is approaching menopause. Menopausal changes cause a change in the menstrual cycle, and also the mucus patterns. Practice of observing body changes will enable a woman to recognise when ovulation takes place, even though it may be irregular.
- A woman's partner is not co-operative about abstaining from sexual intercourse or using a barrier method during fertile days. In many situations, women do not have control over whether or when to have sexual intercourse. It is therefore crucial to make efforts towards changing the power balance between men and women.

The effectiveness of the method depends on how accurately the woman can predict ovulation, as well as the strict avoidance of unprotected genital to genital contact during fertile days. Used correctly and consistently, the FA Method can be as effective as the condom.

The advantages of the FA Method are many. It is a safe, reversible method with no side-

effects whatsoever. Awareness of the body processes and the reproductive cycle contributes to greater control over the body. Most women find that using the FA method gives rise to greater self confidence and autonomy. The fact that successful practice of FA as a method of fertility control requires the co-operation of the male partner is sometimes seen as a "disadvantage". Yet, it can be a positive factor when men are made responsible partners in the process of fertility control. The experience of many groups teaching FA has been that men too are interested in participating in fertility control, and this trend needs to be encouraged.

B. Barrier methods (Methods that prevent egg from meeting sperm)

Barrier methods work by literally forming a barrier between the sperm and egg. The following kinds of barriers are currently available:

1. Male Condom

This is a cylindrical latex sheath worn over the penis during intercourse. It blocks the release of sperms into the vagina. It is unrolled onto the erect penis before any vagina-to-penis contact because long before ejaculation occurs, the man may discharge a few drops of fluid which may contain sperm, or could transmit STDs. After ejaculation, the penis should be carefully withdrawn from the vagina so as not to spill any semen in or near the vagina. The condom is then unrolled and disposed off. A condom should never be used more than once. The male condom is one of the most effective and safe methods of contraception. It has no side effects on the man or the woman. Condoms are also highly effective in preventing AIDS and other STD's. Another advantage of the condom as a spacing method is that it is completely reversible. Condoms are the most widely available contraceptive.

Focussing on Condoms (Box)

Some people, especially men, feel that condoms reduce the spontaneity and pleasure of sex. In addition some people are allergic to latex rubber. If condoms are of poor quality, or have been stored too long, especially in a hot place, they may tear or leak. If there is not enough lubrication during sexual intercourse, or if the condom is incorrectly used, it may also tear e.g. if it is not rolled on smoothly. The reluctance on the part of many men to share the responsibility of birth control is a major reason why many men do not use condoms, even when they are so effective. However, if putting on the condom becomes part of sex play, it can even become a pleasurable activity. Considering that condoms are so safe, and have the added advantage of protecting against HIV and other STDs, it is worth putting in a lot of effort into encouraging men to use condoms.

2. Diaphragm

The diaphragm, invented in the 19th century, was a major breakthrough in giving women control over their fertility. The diaphragm is a circular, dome-shaped rubber disc with a firm rim inserted into the vagina to cover the cervix and block the entrance of sperm. It was earlier thought that for maximum efficacy, diaphragms and cervical caps must always be used with a spermicide (a cream or jelly which inactivates or kills the sperms).

However, newer types of diaphragms now being manufactured are also used without spermicide. Studies show that efficacy rates without spermicide are comparable to those with the use of spermicide.

The initial fitting of the diaphragm is done by a doctor/health worker, since the diaphragm is available in different sizes ranging from 2 to 4 inches, depending on the size of the upper vagina. Once the diaphragm of the right size is fitted, the woman herself inserts and removes it when necessary. It is filled with a spermicidal jelly or cream and placed right up inside the vagina until it covers the mouth of the uterus. It should be put into place before any sexual contact is made and left there for at least 6 hours after intercourse so that the spermicide can kill the sperms that are left in the vagina. Afterwards, it is removed, washed with soap and water, thoroughly dried and kept away until the next use.

The possible problems with the diaphragm include: local irritation due to the spermicide; the diaphragm itself may push forward and cause cramps in the uterus, bladder or urethra. For some women, this can lead to urethritis or recurrent cystitis. It should therefore not be used by women who are prone to urinary tract infections, or who have a prolapsed uterus. The diaphragm could also push backward on the rectum, causing discomfort. Most of these problems may mean that the diaphragm is of the wrong size. Getting the right size would help.

All this may sound complicated, but with a little practice using a diaphragm is very simple. It has several advantages. It is completely safe, and has no serious side-effects. It is completely reversible, since one only has to stop using the diaphragm when one wants to get pregnant. A significant advantage of the diaphragm is that it is in the control of the woman.

Though the government considers that diaphragms have a high failure rate and does not promote its use, the experience of many women's organisations and other NGO's is different. The diaphragm, with proper awareness and training has proved to be an effective and safe contraceptive. Its other advantages include that it has no side effects. At present, the diaphragm is not easily available in India. A few women's organisations have experimented with importing and distributing it. The cost of one diaphragm is about Rs 400. While this may seem a bit expensive, it must be remembered that a diaphragm is reusable and lasts about 3 years if well maintained.

3. The Cervical Cap

This is a thimble-shaped rubber cap that fits snugly over the cervix. Like the diaphragm, the cervical cap keeps sperm out of the uterus. The cap is designed to create an almost airtight seal around the cervical opening. Suction, or surface tension, hugs it close to the cervix. It is used with spermicide, which both inactivates sperm and strengthens the suction seal between the cap and the cervix. The cervical cap, because of its size, may be more comfortable than the diaphragm. It is also a good choice for women who experience repeated urinary tract infections when they use a diaphragm if this problem is caused by pressure from the diaphragm rim. Unfortunately the cervical cap is not available in India.

4. Female Condom

The female condom is a soft, loose-fitting sheath made of polyurethane, which is closed at one end. The female condom works by blocking the release of sperm into the vagina. It is inserted into the vagina before sexual intercourse. A flexible polyurethane ring is located at either end of the device, one at the closed end which covers the cervix, and the other at the open end which remains outside the vagina. The ring outside the vagina adds to the protective effects of the female condom by creating a barrier between the labia and the base of the penis. The female condom should be inserted before any sexual contact is made. After intercourse it must be removed with care to prevent any sperm from spilling into the vagina, before the woman stands up. The female condom combines the features of a condom and a diaphragm. It is inserted into the vagina in much the same way as a diaphragm, without having to take care to directly cover the cervix. Like the male condom, the female condom can be used only once.

The female condom not only covers the vaginal walls but the cervix as well. As such it is not only an effective contraceptive for preventing pregnancies, like the condom, but is also an excellent safeguard against HIV and other STDs. Amongst its other plus points, it can be inserted in advance of intercourse, as such there is no need to interrupt it. It comes in a standard size and does not need fitting by a doctor. The main disadvantage of the female condom is its cost. It costs as much as \$10 (Rs 450) for a pack of 3 female condoms. Since it can be used only once, it is a prohibitive cost. Another disadvantage is the embarrassing sound produced during sexual intercourse, and also the fact that it makes oral sex unpleasant. Since its outer ring covers the clitoris, many women find that it reduces their sexual pleasure and causes discomfort. Some women may be allergic to latex, and may find it difficult to use a female condom. The female condom is not readily available in India. Its use is mostly among voluntary organisations working on HIV/AIDS.

5. Spermicide

Spermicides are chemicals that are applied into the vagina and work by inactivating or killing the sperms. They are available in the form of foams, tablets (e.g. Today), jellies and creams (e.g. Delfen). The spermicide is inserted into the vagina with the help of an applicator immediately before sexual intercourse. They are not usually used on their own but could be used to increase the effectiveness of condoms or diaphragms. The lowest expected failure rate for spermicides used alone is 6%, while the typical failure rate is 26%. These spermicides do not generally have any serious side effects, though some women may experience genital irritation or allergic reactions.

Box

Traditionally used Methods

A special note should be made of certain practices that are traditionally used. Although these methods may be safe and without side-effects, they have a low effectiveness. At best, they would slightly reduce the probability of getting pregnant as compared to using no method at all.

1. Breast feeding

After child birth, it takes some time, usually a few months, for the woman's body to begin menstruating and for ovulation to take place. Lactational Amenorrhoea is the period during breast feeding when there is an absence of menstruation. This period is prolonged in women who carry out "complete breast feeding" i.e. a woman is nursing her baby on demand, both during the day and night, and she is exclusively breast feeding i.e. no top feed is given. During lactational amenorrhoea, the chances of getting pregnant are reduced. However, it should be noted that ovulation takes place before the first menstruation. Hence, it is possible to get pregnant even without experiencing a menstrual period. Such conceptions are called, in some regions of North India, as "laam ka bachcha". Combining this method with Fertility Awareness greatly increases its effectiveness.

LAM – Lactational Amennorrhoea Method

LAM is considered a formal method of contraception by many authorities. Practicing LAM involves strictly following the following guidelines:

- LAM is effective if the childbirth was less than 6 months back
- The baby should be exclusively breast fed
- The baby should be fed at least once every 6 hours
- Menstruation must not have started

2. Coitus interruptus/ Withdrawal

Traditionally, withdrawal is used throughout the world as a method passed on from one generation to the other. It involves withdrawing the penis from the vagina before ejaculation so that the sperm is deposited outside the vagina.

Withdrawal is not very effective because cannot always withdraw his penis in time to avoid contact with the vagina and vaginal lips. Often, a man cannot tell well in advance when he is going ejaculate, and thus fails to withdraw in time. Furthermore, even if he does withdraw in time, his pre-cum that appear as soon as he has an erection, contains small but sufficient amount of sperms to cause pregnancy.

C. Methods that prevent Fertilisation

1. Intrauterine Device (IUD)

An IUD usually is a small, flexible plastic device that fits into the uterus. Most contain either copper or synthetic progesterone. The IUD is inserted in the uterus of the woman through the cervix. Once the IUD is in place, the strings (usually two) of the IUD extend down into the upper vagina. A woman can feel if the IUD is still in place by inserting her finger into her vagina and touching the strings.

The mechanism of action of the IUD is not yet fully understood. The most widely accepted theory is that it prevents fertilisation. IUDs (especially those that contain copper) cause an inflammation or chronic low-grade infection in the uterus. These changes may damage or destroy sperm or interfere with their movement in a woman's genital tract, making fertilisation impossible. IUDs may also speed up the movement of

the egg in the fallopian tube, causing the egg to arrive in the uterus too soon to be able to join with sperm. Even if fertilisation does manage to occur, the disturbance caused by the foreign body in the uterus prevents implantation.

The most commonly used IUD in India today is the Copper-T. These IUDs are used for about 2-3 years, after which they have to be changed. The IUD must be inserted inside the uterus by a doctor, during the menstrual period or soon after to ensure that there is no pregnancy at the time of insertion. The IUD is very effective as a contraceptive. However, it could have several side effects, some of them severe:

- Severe cramps and pain beyond the first 3-5 days after insertion
- Heavy menstrual bleeding, or bleeding between periods, possibly contributing to anaemia
- Rarely, perforation (piercing) of the wall of the uterus. Embedding may also occur if the lining of the uterus grows around the IUD. Embedded IUDs cause more pain during removal, sometimes necessitating a D&C procedure (Dilation and Curettage).
- Pelvic Inflammatory Disease (PID) [infection in the uterine lining, uterine wall, fallopian tube, ovary, uterine membrane, broad ligaments of the uterus, or membranes lining the pelvic wall. May be caused by a variety of infectious organisms including gonorrhoea and chlamydia] is twice as likely to occur in women using IUDs as in women using no contraception.
- Ectopic pregnancy is more likely (with copper IUDs, there is a 3% chance) in women using IUDs. An ectopic pregnancy (pregnancy outside the uterus, usually in the fallopian tube) is a serious problem that can cause haemorrhage, and lead to infection, sterility and sometimes death (when emergency medical care is not available).
- IUDs should be chosen as a contraceptive after careful consideration. If one has never had a child, it is advisable not to get an IUD inserted. It is not appropriate for women who are prone to genital infections, who have history of ectopic pregnancy, who suffer from severe dysmenorrhoea (painful menstruation) or who are anaemic.

Most government health centres and hospitals pressurise women to get IUDs inserted straight after a delivery/abortion. This can be extremely dangerous.

2. Non-steroidal pill - centchroman

Marketed in India by the brand name SAHELI or Choice 7, non-steroidal pills work by accelerating the passage of the ova into the uterus. It works even if fertilisation has already occurred. Non-steroidal pills are promoted as an ideal contraceptive by the government. However, although it is not a hormonal pill, it does change the Estrogen-Progesterone functions of a woman's body. Centchroman is also known to have caused ovarian cysts in some users.

D. Abortion

An abortion is the ending of a pregnancy before full term, by expulsion of the foetus from the uterus. A spontaneous abortion or miscarriage is the natural termination (ending) of pregnancy. An induced abortion is also called Medical Termination of Pregnancy (MTP). Despite using contraceptives, a pregnancy may result. Or, pregnancy may be the result of rape, incest, or some kind of coerced sexual encounter. In these situations, a woman may decide to have an abortion. From time immemorial, abortion has been used as a means of

fertility control. External massage, performing arduous physical activity, scraping the uterus with a sharp object, consuming abortifacient herbs and potions have been means through which women have attempted to end unwanted pregnancies. Many societies have imposed strict religious sanctions against abortion, viewing it as the taking away of life. Although abortion is still illegal in many countries, legal, safe, affordable and accessible abortion has been articulated by the women's movement the world over as a woman's right. Induced abortion is legal in India by the Medical Termination of Pregnancy Act, 1972.

During an abortion, the foetus and the placenta are removed through the cervix. Depending on the stage of the pregnancy, different methods of abortion may be used.

(i) Suction:

It is suitable for a 6-8 week pregnancy. In this method a cannula or tube that is connected to a suction pump is inserted through the cervix under either local or general anaesthesia. By suction, the foetal tissue is removed within a few minutes. It does not require a hospital stay.

(ii) D&C (dilation and curettage)

For pregnancies of 8-16 weeks, the cervix is dilated by a diluting rod and then the walls of the uterus are scraped clean with a curette, all under a general anaesthesia.

(iii) Induced labour

For advanced pregnancies of about 16-20 weeks, usually a solution of saline, urea or prostaglandin is injected into the amniotic sac to cause premature labour and expel the foetus. This procedure is carried out under a local anaesthesia and requires a one or two day hospital stay.

Box- How safe is an abortion?

If performed by an experienced doctor under hygienic conditions, an abortion can be safe. But, it is safest within the first 12 weeks. If not carried out carefully complications can arise. E.g. if an abortion is incomplete, and some foetal/placental tissues remain inside, it could result in serious infections and severe bleeding. Other complications include blood loss, infection in the vagina and/or the cervix, perforation of the uterine wall and damage to the cervix. The trauma of having to undergo an abortion could lead to depression and other psychological problems.

Abortions should be considered as a back-up method of fertility control, in the event of contraceptive failure or pregnancy due to coercion (for instance, rape). Repeated abortions are a health hazard. Abortions are not safe or legal after 20 weeks gestation. Government hospitals though they perform abortions free of charge lay down certain conditions like one has to insert an IUD or Norplant or get sterilisation done. This is unethical and illegal, and should be resisted.

(iv) The abortion pill

Known as RU-486, the abortion pill is an anti-progestin pill that is currently being tested out in India. It has been found to be extremely unreliable on its own and hence is administered along with a prostaglandin vaginal suppository. The RU-486 is effective as an abortifacient only in the first 6-8 weeks of pregnancy. It works by bringing down the

level of progesterone (necessary to maintain pregnancy), thereby creating conditions unsuitable for pregnancy. The apparent convenience of the pill has potential for it to be very widely used. However, nothing can be said with surety about the safety of the pill and it is not advisable to take it yet. The abortion pill should be taken only under medical supervision, as it could cause uncontrolled bleeding. Some known side effects include uncontrolled vomiting and nausea, severe bleeding that could lead to a collapse. It could take up to 22 days for abortion to happen and one could bleed all that while. Moreover, since RU-486 is effective only for very early pregnancy, the effect of RU-486 on the foetus in case it does not cause an abortion, has not been adequately studied. i.e. birth defects have not been ruled out.

E. Hormonal methods

Causing the woman not to produce eggs and/or the man not to produce sperms.

Hormonal methods work by influencing the hormones estrogen and progesterone in the body and thereby stopping ovulation or sperm production. They also have the effect of thickening the cervical mucus (which prevents sperm from entering the uterus), and in some cases also by causing changes in the uterus and fallopian tubes which prevent fertilization. Hormonal methods disturb the delicate balance of hormones in the body. They may have serious side effects and may affect various parts of the body in addition to the reproductive system i.e. they cause systemic changes. At the same time the government contraceptive providers promote them as an ideal contraceptive because they are highly effective and easy to administer.

Box-Disadvantages of Hormonal Contraceptives

Women's organisation have highlighted the following specific disadvantages of hormonal contraceptives:

- (i) effect on the functioning of the brain, causing headaches, dizziness, weight gain, anxiety, depression, tiredness, hypertension, decreased libido, digestion problems, vaginal discharge and soreness, skin problems and loss of appetite, etc. They also cause changes in cardio-vascular functioning (heart disease, stroke). The possibility of cancer risk has not been satisfactorily ruled out.
- (ii) menstrual chaos: The high levels of hormones in the body can cause irregular bleeding, persistent spotting, heavy menstrual bleeding prolonged periods or even total absence of periods.
- (iii) return of fertility not certain: current research does not validate the assertion made by the government that a woman will promptly regain her fertility if she stops using the hormonal contraception. Since these methods are being promoted as spacing methods, this is a serious concern.
- (iv) The government is promoting these methods without having sufficient information on the long term effects on human beings.
- (v) If a child is conceived due to failure of the method, or immediately after the woman stops using the method, or if hormonal contraception is used on a pregnant woman the resultant child can have birth defects, that may show up as late as puberty. Neither the government nor the drug companies have conducted any studies to find out what might happen.

(vi) Hormonal contraceptives require very close monitoring at every stage by trained personnel using sophisticated equipment. This should be done before use, to find out any contra-indications, during use to determine any adverse reactions, and after use to check for possible after-effects. Unfortunately such basic facilities are not available in Indian primary health centres and government hospitals.

(vii) Besides the pill, hormonal contraceptives are long-acting e.g. injectables (such as Net En and Depo Provera), implants such as Norplant, nasal sprays etc. They have an effect which ranges from 2-3 months (injectables) to 5-6 years (implants). Thus, even if a woman wishes to stop using the contraceptive, the effect of the hormone lingers in her body for a while after she stops. A further problem with long-acting hormonal contraceptives is that they place the control over fertility in the hands of the health-service provider rather than in the hands of the woman. Women's organisations the world over, and in India, have been opposing the introduction of long-acting hormonal contraceptives not only because of their hazardous effect on health, but also because of the potential for abuse inherent in these forms of delivering contraceptives. (end Box)

1. Oral Contraceptives (OCs)

The "Pill" was heralded in the 1960s as a symbol of sexual freedom for women. It appeared to be a 100% effective, simple and wonderful alternative to the methods then available. Many women first heard about the dangers of the high-dose estrogen pill (blood clots, heart attacks, strokes, depression, suicide, weight gain, decreased sex drive) when they read Barbara Seaman's book, "Doctors' Case Against the Pill," published in 1969. Efforts by women and consumer activists in the late 1960s led to modifications of the Pill as well as special package inserts listing the possible negative effects and complications. Because most of the negative effects are associated with high dosages of estrogen, drug companies reduced the estrogen content of the pill, and also began to develop progestin-only pills. In the United States, Germany, and most countries in the West, the Pill is available only by prescription. In India, however, OCs are available over-the-counter (OTC) i.e. without a doctor's prescription. Recently, vigorous "social marketing" strategies have resulted in OCs being made available more freely, and through non-conventional outlets. However, this needs to be viewed with caution. Firstly, OTC availability eliminates the clinical screening needed to detect health conditions which make use of OCs risky. When monitoring and follow-up is absent, treatment of side-effects and detection of complications is not possible.

Different Oral contraceptives include:

Combined Oral Contraceptive (OC)

Combined oral contraceptive pills contain two hormones, estrogen and progestin, in different proportions. They prevent pregnancy primarily by inhibiting the development of the egg in the ovary by raising the level of estrogen at the beginning of the cycle. Today's low-dose combination Pills (like Mala-D) are relatively safer than the high dose combination Pill (like Ovral). However, combined OCs are not suitable for all women.

Box

Who should not use Combined OCs?	Who Should not use Progestin-only Pills?
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<p>Combined OC Pills are dangerous for women with the following conditions:</p> <ol style="list-style-type: none"> 1. Any disease associated with excess blood clotting – bad varicose veins, thrombophlebitis (clots in veins, frequently in leg), pulmonary embolism (blood clot that has travelled to the lung, usually from the leg). 2. Stroke, heart disease, coronary artery disease 3. Hepatitis or other liver diseases 4. Heavy smokers 5. Breast-feeding and less than six weeks after giving birth 6. Pregnancy ended within the past three weeks: there may be an increased risk of thromboembolism during this period. 7. Migraine headaches 8. Moderate/severe hypertension (blood pressure 160/100 or more) 9. Diabetes with certain vascular complications 10. Liver tumours or liver cancer, cancer of the breast (or history of cancer of the breast) 11. Women who are unable to take pills consistently and correctly. Forgetting pills in between the cycle could result in pregnancy. 	<p>Women with the following conditions should not take progestin-only pills:</p> <ol style="list-style-type: none"> 1. Unexplained vaginal bleeding 2. Breast cancer <p>Women with the following conditions should use progestin-only pills only as a last choice:</p> <ul style="list-style-type: none"> • Hepatitis • Jaundice • Cirrhosis of the liver • Benign or malignant liver tumours • Functional ovarian cysts • Cardiovascular complications • History of breast cancer • Women who are breast feeding • Women who are unable to take pills consistently and correctly. Forgetting pills in between the cycle could result in pregnancy.
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Progestin-only pill

While combined oral contraceptives stop ovulation, progestin-only pills, prevent pregnancy by increasing the thickness of cervical mucus, slowing down the motility (movement) of the sperm as well as the egg, and not allowing the uterine lining to develop properly.

The Pill has many advantages – high effectiveness, convenience, no interference with sexual intercourse, proven reversibility etc. However, there are several unpleasant side-effects and long term effects which should be noted .These are highlighted in the Box above.

2. Injectable Contraceptives

Depo Provera (Depot Medroxyprogesterone Acetate) and Net En (Norethisterone Enanthate) are progestin-only injectable contraceptives. The contraceptive effect of Depo

Provera lasts for 3 months, and that of Net En for 2 months.

Injectables seem to be a convenient method of birth control. However, there are many short-term side-effects and long-term health hazards associated with use of injectables. Since injectables are delivered in very high doses, and their effects are long-acting, the seriousness of side-effects far outweighs those of the pill. Even if a woman desires, the effects of injectables cannot be withdrawn until they wear off in 2-3 months.

The health hazards associated with use of progestin-only injectables include:

- Menstrual disturbances ranging from prolonged spotting, excessive bleeding to complete absence of bleeding
- Atherosclerosis – thickening of blood vessels and cardiovascular disease
- Thromboembolism – development of blood clots at unexpected sites, resulting in damage to heart, lungs and brain etc.
- Osteoporosis/loss of bone density, resulting in higher incidence of fractures
- Weight changes
- Other metabolic changes resulting in changes in sugar levels, depression, fatigue, loss of sexual desire etc.
- Return of fertility is not predictable(a serious limitation in a spacing method)
- Cancer risk – an unresolved issue
- Adverse effects on the foetus (in case of accidental pregnancy) have not been ruled out

That the public health system is in shambles is common knowledge. The Family Welfare Programme is not equipped to introduce long-acting injectables on a mass scale. Ruling out contraindications, skill while injecting, timing of the first injection and subsequent injections, are of crucial importance. Lack of monitoring and follow up of users, and inability to deal with medical emergencies make the introduction of injectables even more dangerous. Lack of informed consent and enforcement of disincentives imbue injectables with a high potential for abuse. The apparent “convenience” of injectables further reinforces women’s powerlessness in matters of fertility control. Presently, injectables have not been licensed for introduction in the National Family Welfare Programme. They were registered in 1994 for use only by private practitioners and “social marketing” by NGOs.

3. Sub-dermal implant – Norplant

Sub-dermal implants are a set of 6 rods of flexible silastic rubber capsules filled with the synthetic progestin levonorgestrel. Each rod is the size of a matchstick. The implant is usually inserted under the skin of the forearm of the woman. Norplant is designed to last for up to 5 years. It can be removed only by a surgical procedure by trained personnel. This progestin-only contraceptive works in three ways: by inhibiting ovulation, by thickening and decreasing the amount of cervical mucus, and by thinning the endometrial lining to prevent implantation.

Norplant is a highly effective and convenient contraceptive. Its use, however, is associated with several health risks common to progestin-only contraceptives, similar to those of the injectables. Many of these are seriously life-threatening, especially in a

situation where proper monitoring and follow-up is not available. Many of the side-effects of Norplant make the quality of life for a woman miserable – having to deal with headaches, depression, mood swings, fluid retention and other unpleasant side-effects. Recently (August 1999), following cases filed in US courts, American Home Products Corp., the parent of Norplant maker Wyeth-Ayerst Laboratories had to pay over \$50 million to more than 36,000 women to settle claims that Norplant caused headaches, irregular menstrual bleeding, nausea and depression. Norplant has completed all the stipulated clinical trials in India. However, it has still not been introduced on a mass scale in the National Family Welfare Programme.

4. Anti-fertility vaccine (under trial)

Anti-fertility vaccines use the body's natural immune system to generate a immune response against hormones essential for pregnancy. The chosen reproductive cell is linked to a 'carrier' molecule like tetanus toxoid or diphtheria toxoid, so that the immune system perceives it as "foreign" to the body. Vaccines aimed to create antibodies against the development of ova, sperm, and pregnancy hormones are currently under development. The most advanced of these is the anti-hCG (human chorionic gonadotropin) vaccine being developed at the National Institute of Immunology, New Delhi, as well as the World Health Organisation. Phase III clinical trials have been conducted on a 3-month vaccine, but the efficacy is as low as 80%.

Since Anti Fertility Vaccines interfere with the immune system, their effects on any existing diseases or allergies are yet to be fully determined. Research has shown that immuno-complex diseases may result following use of Anti Fertility Vaccines. The reversibility has not been established beyond doubt – a serious limitation for a spacing method. If a woman takes the vaccine accidentally when she is pregnant, or there is contraceptive failure, the effects on the foetus have not been fully studied. Short term side-effects include fever, infection, pain and lesions at the site of vaccination, generalised rash, nausea and giddiness. Another serious concern, especially in the Indian context is the potential for abuse inherent in anti-fertility vaccines. Women can be vaccinated without their knowledge and consent. When medical technology is used to commit human rights violations, such technology needs to be questioned.

The International Campaign Against Hazardous Contraceptives and Coercive Population Policies (of which several groups in India are members) has been campaigning since 1993 to call a halt to research on Anti fertility Vaccines, on the grounds that the risk to the health and well-being of users and potential foetuses from the manipulation of the immune system for contraceptive purposes cannot be justified by any advantage over existing contraceptives.

F. Permanent Methods

A man or a woman can go for sterilisation through surgery. This procedure involves permanently blocking or cutting off the tubes which carry the egg/sperm. Such sterilisation is considered permanent and irreversible. With newer medical techniques, re-canalisation (rejoining of tubes) can be performed, but it is not always possible or

successful. Moreover, it is very expensive. Sterilisation should therefore be considered permanent and irreversible. Sterilisation is very highly effective. It is appropriate for people who have attained the desired family size and are sure that they do not want any more children.

1. Vasectomy/ Male sterilisation

Vasectomy is a surgical method of sterilisation for men. It blocks the vas deferens in the male so that sperms cannot travel to the penis with semen. The man however continues to ejaculate and it does not affect his sexual libido or performance in anyway. Adequate and sensitive counselling can help to alleviate anxieties about "manhood" and sexual performance.

In "no-scalpel" vasectomy, only a tiny hole is made on both sides of the scrotum to expose the vas deferens which is then cut, tied or clipped under a local anaesthesia. Vasectomy is a minor and simple surgery, but the man should rest for at least 48 hours after the operation, and should not lift any heavy objects for a week. One should resume sexual intercourse only after all signs of discomfort have gone, in any case not before a week. An alternative method of birth control must be used for at least 2-3 months after the operation, as sperms can live in the sperm duct for up to 3 months. In case, the operation is followed by high fever, excessive or continued bleeding, swelling or pain do consult a doctor immediately.

It is safer and simpler for a man to be sterilised because the male genitalia, unlike that of the female is external. Hence, sterilisation involves less interference to body organs and less complications. Recent studies indicate that men who have had a vasectomy may have an increased risk of prostate cancer. There are no other major long term risks associated with vasectomy.

2. Tubectomy/ Female Sterilisation

Under this method a puncture or a small incision is made in the abdomen to gain access to the woman's fallopian tubes which are then cut, tied or clipped. This is done under a local anaesthesia. It blocks the fallopian tubes in the female so that the eggs produced by the ovaries cannot unite the sperm. Female sterilisation is very effective if performed properly, though complications can and do arise. This could include infections, internal bleeding, perforation of the uterus and/or the intestines. It could also lead to heart problems, irregular bleeding, severe menstrual pain, and the need for repeated D & Cs or even a hysterectomy. A doctor should be immediately considered in such a case. Proper precautions need to be taken before and during sterilisation. One needs to rest for about 48 hours after the operation. Normal activities can be resumed within 2-3 days but one must not lift heavy objects for about a week. Sexual intercourse can be resumed once she is comfortable with it, usually after a week.

The risks of tubectomy are those for any major abdominal surgery – cardiac irregularity, cardiac arrest, infection, internal bleeding, perforation of a major blood vessel. These risks increase manifold when tubectomy is performed in settings where due care is not taken, for e.g. in family planning "camps" where huge number are sterilised. Mobile

campus are even more problematic since the possibility of monitoring and follow-up does not exist.

Laparoscopic techniques may involve specific problems such as internal burn injuries or punctures to other organs or tissue, skin burns, puncturing of the intestine, perforation of the uterus, and carbon dioxide embolism (which may cause immediate death)

Emergency Contraception – (box)

After unprotected sex, emergency oral contraception can prevent pregnancy. It is also called the “morning-after” or “post-coital” contraception. It is of particular relevance in situations where a woman has been forced to have sex against her will (rape), a condom has broken, unplanned sex occurred etc. Emergency contraception can be used only up to 72 hours (three days) after unprotected sex. It involves taking 4 standard dose or low-dose oral contraceptives such as Mala-D or Mala-N.

Side-effects include nausea and vomiting, and a disruption of the next menstrual period.

It is not very clear how emergency contraception works. It is thought to prevent ovulation, and may also contribute to disrupting fertilisation if it has already occurred.

However, it is not 100% effective. The average chance of pregnancy due to one act of unprotected intercourse in the second or third week of the menstrual is 8%, and after emergency contraception it gets reduced to 2%.

It is important to remember that in case emergency contraception does not work, the chances of birth defects in the foetus cannot be absolutely ruled out. Hence, it is important to be very cautious in the use of emergency contraception, and have adequate backup of legal and safe abortion services.

Section Two

Issues And Debates In India

Contraception or Family Planning ?

This is a debate that is going on in India for a long time. The government in its different programmes has always been using the term family planning, to such an extent that many service providers see the two as the same. Unfortunately this is not the case. Family planning takes place only within the framework of the family, where the two partners make conscious decisions. These include the number of children desired, the timing of children and the spacing of children. The factors that affect the decisions should ideally include the health of the mother and the child, the mental health of the mother, the financial condition of the family, the emotional care that can be given to the children, and so on. Contraception, on the other hand, is a need of many more categories of people who may also be sexually active.

BOX- Those whose contraceptive needs get ignored by Family Planning

A significant number of sexually active persons who fall outside the pattern of monogamous heterosexual marriage may need contraceptive services. Let us look at some of these potential users of contraception:

Relations outside marriage: Contraception is probably more important in heterosexual relations outside of marriage (than within it) for preventing conception, STD's, especially HIV and the medical and social consequences that are attached to any of them. Such relationships include pre and extra- marital sex.

Sex workers: They comprise the most frequent users of contraceptives, being vulnerable to pregnancies as well as HIV/AIDS and other STD's. However they are not targeted by the government as prospective users of contraceptives.

Adolescents: Adolescent sexual activity, even though presumed by many to be non-existent, is a definite reality. They are unfortunately denied access to information about and access to contraceptives. As a result teenage abortions are very common in India.

Single men and women: Many single men and women who are sexually active, do not fall into the target group traditionally identified by the authorities. The number of such people is increasing in our society because of the delay in the average age for marriage for both men and women, and more and more people deciding to keep out of the marriage institution for various reasons.

Men and women who are attracted to the same sex: Gay and lesbian people who may or may not be married are not even recognised by the authorities, and no efforts are made to give them information and access to contraceptives. In fact there have been instances where (e.g. Tihar Jail episode in 1996) access to condoms were denied to prisoners as they were found to engage in homosexual activities.

Already sterilised person and childless couples: The government keeps out those men

and women who have been sterilised, are newly married or otherwise do not have a child. Their names are struck out of the Target couples register. But these persons are still vulnerable to HIV/AIDS and other STD's.

Male responsibility and Participation for contraception

When contraceptives were first promoted in India, male methods like condoms and vasectomy were relatively more popular than the methods for women. Over the years there has been a drastic reduction in the use of these methods. This is partly due to what is often described as the 'emergency excesses' when extreme coercion was used to vasectomise men. But this had taken place over twenty years ago, and the health system is still reluctant to address men in a forthright manner. What has happened as a result of this reluctance is that over these last two decades women have more-or-less been exclusively targeted by the erstwhile target oriented Family Planning programme. This has led to a situation where both men and women have come to consider this trend natural. It is only after the Cairo Conference that the issue of male participation in family planning has started been discussing openly, but in a society as patriarchal as ours, it will take more than that to change the trend that has been established.

In popular imagery the man who is vasectomised is often equated with that of an impotent or emasculated person, and this imagery has been responsible for dissuading many potential acceptors. Condoms have often been discredited for not giving the real feel and pleasure. And with both these methods conveniently out of the way men have withdrawn from the entire realm of taking responsibility for their own fertility behaviour. The lack of responsibility is to the extent that Government programmes often distribute condoms to the wife, thereby further reinforcing the image that contraception is solely the woman's responsibility.

At this point in time the issue is not how to find a more convenient and effective method for men, but of how to change the popular mindset. The Government has of late started promoting no-scalpel vasectomy, but the results are far from satisfactory. There has to be far greater emphasis on the husband's and father's responsibility not only in the popular media but also through systematic training and reorientation of the health department functionaries right from the top to the grassroots.

Reproductive rights and contraception

The International Conference on Population and Development (ICPD), 1994, known popularly as the Cairo Conference, is considered to be a watershed in the field of population and development (see Introduction). Many ground breaking decisions were taken for the first time, which will have a long term impact. The following understanding emerged from Cairo with respect to contraception and reproductive rights : The Individual should have the right to -

- Access to services and information
- Highest Quality of Care
- Reproductive Health Choices , Free of Coercion and Violence

However, in India, family planning and not contraceptive services are provided and that too to a limited number of potential users. There are a number of provider biases: for example, persuading couples with two or more children (at least one a male child: this would then be the 'desired' family size) to adopt a terminal method of contraception, and because women are the 'soft target', to convince them about tubectomy. Considerations about the health of the women are not part of the agenda. It is worthwhile to remember that what individual women need is contraception, or birth control, while the agenda of the government is population control or reduction in numbers. Often, these two goals come in conflict with each other, and in the interests of population control, women's rights are marginalised.

Government services for Contraception – A review

The Government of India through its Family Planning programme is providing free contraceptive services for five methods: condoms, IUDs, oral contraceptive pills, tubectomy and vasectomy. These are available at the PHCs at every development block, and some are available with the ANM (Auxiliary Nurse Midwife) at her Sub Centre in the village. Examining the services in India provided by the government according to the ICPD charter brings to light the following:

Access to services and to information - Access to complete and unbiased information and to proper services regarding contraception by those who need it, especially women, is a basic right. They should know about the various contraceptive options available to them and the relative advantages and disadvantages of each method, without any information being withheld, before they can decide on a particular method of contraception. However in India, the government machinery is more often than not still involved in promoting particular methods, and the client is seldom if ever provided accurate information about advantages and disadvantages with which to make her/his choice.

Quality of care – Quality of care comprises of a number of interlinked facets. It includes the respect the service provider has for the client, the competence of the service provider, the availability and accessibility of the appropriate service, availability of follow-up support and so on. If one considers the kind of service that is available to millions of women in India through the peripheral service delivery system the lack of quality care is clearly evident. The service providers are often technically inappropriately trained, their behaviour towards the client displays complete lack of respect, follow-up support is absent when required, the list can be endless.

Contraceptive choices and freedom from coercion - The Indian Family Planning programme was well known for its target oriented-ness and the incentives and punishment regimes. Since the ICPD the policy has changed with the adoption of the Target Free Approach (in April 1996, which was subsequently renamed Community Needs Assessment approach). Unfortunately this change has not been internalised and many state government and certainly many service providers continue with targets and incentives. Tubectomies still remain the order of the day, and in many states incentives

have been increased manifold.

Violence, gender and contraception

Contraception is one area in which gender based violence is perpetrated on women both within the family and by the service providers. In Indian society with its wide gender disparities, it is doubtful whether women can negotiate contraceptive use with their partners. It may be difficult for the woman to insist that her male partner take up responsibility and use contraception. This is true both within and outside marriage. Men, when they do not want to use a contraceptive, can also force their women not to use one, irrespective of whether the woman wants a child or not. The result of this is that women often get saddled by an unwanted pregnancy or an induced abortion. In cases of abortion the woman has to face a host of other complications. The pressure to bear male children and to go through many unwanted ones in order to do so is also a form of violence associated with the issue of contraception.

In case of the state health delivery system the coercion and violence about contraception takes different forms. Many government centres/ service providers insist that a woman has to get an IUD inserted before conducting an abortion or insist on sterilising a woman (or inserting an IUD into her) when she comes to deliver a child. Then there is the pressure on the woman by the service provider to adopt a particular method. The absence of proper contraceptive information and services which leads many women to bear more children than they would ideally like or to go through unsafe abortions can also be considered from the violence angle.

Provider control vs user control

This debate is not very clearly articulated in many circles but if one is viewing contraception from the rights perspective this debate is essential. Provider controlled contraceptives refer to those methods where the use of the contraceptive depends to a great extent on the service provider for example the injectables, the permanent methods and the implants. The user cannot use these without the help of the service provider. These methods also have the advantage of long term use, which means that they have been used by many countries in order to ensure population control. User controlled methods give the user autonomy which also means that the user may choose to become pregnant, which population control regimes are keen to regulate. Provider controlled methods also imply that the provider is accessible and supportive in cases of complications and side-effects. In health service delivery systems like ours, this becomes very difficult to ensure.

Clinical Trials, Human rights and contraceptives

Clinical trials are essential for the introduction of safe drugs and methods into the country. Unfortunately, when the government carries out trials on human beings through its network of government hospitals, family planning centres and teaching colleges, it is

often not committed to the highest standards of ethics. Its personnel are often allowed to get away with all means fair and foul. So if a new drug or contraceptive is under trial, chances are:

- That you will not be informed that it is being tested upon you.
- That the possible side effects the drug could cause will be made light of.
- You will not be asked for your consent to be a part of the trial.

Or all the above will be done in the most casual manner, taking the thumb impression of an illiterate person on a form which is in English. There have been a number of cases in recent years when such irresponsible research was undertaken, which have been brought to light.

Box

Informed consent

This is a basic condition for making any individual a part of a trial of a test/research programme. One should be told about:

- the fact that drug device is being tested
- the risks you are exposed to.
- only voluntary testing, no pressure or incentive.
- one should be given a thorough check up, adequate care and follow-up.
- the responsibility for your well-being during and after the test period lies with the testing agency.
- you can take action if you are discontent with the treatment you are getting.

Section Three

Implementing A Contraceptive Programme

Family Planning programmes are perhaps the most popular non-governmental intervention in the health sector. Infact non-governmental intervention in this shpere took place much earlier than the Government interventions started. The Government also has a large number of attractive schemes for non governmental organisations to take up this activity. Within the Governmental sphere Family Planning remains the most important activity, we have separate department looking after family welfare. Even in the new RCH regime the importance of Family planning has not declined and in order to include the NGOs the new Mother NGO scheme has also been lauched.

There is a great unmet need for contraception in India, and it is crucial to enable women to take informed decisions about birth control, so that they may not have to undergo needless pregnancies and abortions. Thus programmes focussing on contraception are essential to provide women in the remote and marginal areas access to information and services about contraceptives. But one needs to be careful to follow a model that allows all potential users access to these inormation and services. Further more one also needs to respect the right to free and infomrmed choice of the client. While target setting or more correctly estimating indicators or change are essential for programme monitoring it is not advisable to give these greater importance than the communities needs. The Community Needs Assessment Approach lays down the principles of generating the contraceptive needs of the communy together with the community. One needs to improvise and devise actual ways of doing so.

Service provision is a key element that needs to taken care of because once the needs have been generated it would be fatal not to provide the services. Despite the popular notion that Goivernment supplies of condoms get used as ballons by village kids there is a demand supple gap at the community level. Today the need for contraception is clearly exoressed by most communities and the main factor which stops them from achieving desired family size is often the lack of services. Many organisations have resorted to a social marketing approach where instead of providing free contraceptives, the organisations assists the community in accessing cheap but reliable contraceptives from the market.

Some features which could be included in a contraceptive programme

1. It should be part of a more holistic reproductive health package rather than a stand aloone contraceptive programme
2. It should actively promote male participation and involvement in contraception
3. The programme should be integrated and include IEC and service provision
4. The IEC should be geared to reduce gender disparities in the community especially with regard to contraception
5. The information provided on different contraceptives should be un biased and include both advantages and disadvantages. There should be no hidden agenda as far as

- methods are concerned
6. Spacing methods should be especially promoted
 7. There should be provisions for confidential counselling services
 8. Women should be empowered for contraceptive negotiation
 9. Services should include systematic follow-up care
 10. The programme should not ignore the contraceptive needs of other people who are not strictly eligible couples

Contraceptive Research

Contraceptive research could be of either of three kinds- Research for developing new contraceptives, research or field studies to determine efficacy, side effects and acceptability and finally research into contraceptive needs and experiences. Thus the research could be biological or social. While many research laboratories are involved in biological research in order to find the ideal contraceptive NGOs can get involved in social research either in testing efficacy and acceptability or in studying needs and experiences. In case of either forms of research the organisations must ensure

- Full regard for ethics, insist on informed consent for any testing
- Promote research on male contraceptive methods
- Promote qualitative research on knowledge, attitudes and experiences of different client groups regarding contraceptive use

Advocacy

Contraceptives are a very important issue in a country like India which is so concerned with its population. There are five methods of contraceptives being promoted through the family welfare programme, while some others were tried but not introduced. There were serious protests against some of these as they were not considered safe in the prevailing circumstances. There needs to be constant vigilance by citizens organisations in order that the contraceptive needs of the poor are properly met through the government system. Some of the issues around which this vigilance may be maintained are

- The quality and reach of government services
- Demand for more women- friendly and non-invasive safe contraceptives
- Monitor new contraceptives being tried and promoted, from the point of view of safety.

Organisations Working On Contraception AND Family planning

As mentioned earlier there are a very large number of organisations working on the issue of family planning. Many of them are supported by the Government. While earlier the Government norm was to fund programmes which focussed exclusively on Family Planning, in the last two years, the nature of the programmes has changed and the term used is Reproductive and Child Health, but the emphasis remains on Family Planning and Contraceptive Prevalence.

There are some extremely large autonomous organisations which are involved in promoting Family Planning through community based interventions like the Pariwar Seva Sansthan and the Family Planning Association of India. Other organisations like JANANI and Population Services International are working on promoting contraceptives through the social marketing approach.

In the state of Uttar Pradesh there is a huge multi-million dollar project called State Innovations in Family Planning Services Agency (SIFPSA), funded by the USAID, Innovations in Family Planning Services (IFPS) which is also involved in promoting family planning programmes by supporting the Government in the state, NGOs, corporate houses and cooperatives. There are a large number of international agencies which also involved in training on different aspects of family planning and contraception in the country- these include CEDPA, AVSC International, INTRAH/PRIME, and so on.

There are also some other organisations working on the advocacy aspect of family planning and these include Forum For Women's Health, Jagori, Saheli, which have been vigorously trying to resist the introduction of injectibles and implants. Other organisations which are involved in research around the issue include CEHAT, Population Council, ICRW, CORT, FRHS, FRCH and so on.

Addresses of all the organisations referred to above are given below:

AVSC International IFPS Liason Office, 4/2 Shantiniketan, New Delhi - 110021	Jagori C - 54, South Extension Part II, New Delhi Tel. 6257015
Centre for Operation Research Training(CORT) 405, Woodland Apartment, Race Course, Vadodra, 390007 Gujarat	FFWH c/o Swatiya Manorama, 9. Sarvesh, Govind Nagar, Thane (East), Maharashtra, 400 603
Centre for Enquiry into Health and Allied Themes (CEHAT) 2 nd Floor, BMC Maternity Home, 135 Military Road, Bamandaya Pada, Marol, Mumbai -400059	JANANI c-16A, ShriKrishnapuri, Patna- 800001 Ph-0612-23 7564; 23 7645 Fax-0612 23 7291
Centre for Development and Population	Population Services International

Activities (CEDPA) IFPS Liason Office, 4/2 Shantiniketan, New Delhi- 110021	C-445 Chittaranjan Park, P.O. Box 7360, New Delhi 110019, Ph-011 648 5022, 648 7589, 642 8375 Fax- 011 646 7419 Email- v.del@si.sprintrpg.ems.vsnl.net.in
Family Planning Association of India (FPAI), Bajaj Bhawan, Nariman Point, Mumbai, 400042	Population Council Zone 5A, Ground Floor, India Habitat Centre, Lodhi Road, N Delhi 110003 Tel-011 464 2901, 464 2902 Fax-011 464 2903
Foundation for Research in Community Health (FRCH) 84/A R.G Thadani Marg, Worli, Mumbai	State Innovations in Family Planning Services Agency (SIFPSA) Om Kailash Towers, 19, Vidhan Sabha Marg, Lucknow 226001
Foundation for Research in Health Systems (FRHS), 6, Gurukripa, 183 Azad Society, Ahmedabad 3800015	Saheli Unit Above Shop 105-108, Defence Colony Flyover Market (Southside), Defence Colony, New Delhi 110 024
International Centre for Research on Women (ICRW), C/o Anuradha Jain, F-81 East of Kailash, New Delhi - 110065	PRIME/INTRAH 53 Lodhi Estate, New Delhi-110003 Phones-011-464 8891,463 6312 Email- intrah@giastl01.vsnl.net.in
	Parivar Sewa Sanstha (PSS) 28, Defence Colony, New Delhi – 110024 Phones – 011-4617712/9024

Mother NGO Scheme- Box

The Mother NGO scheme has been launched by the Department of Family Welfare, in the ministry of Health and Family Welfare. Under this scheme NGOs are invited to send projects for becoming Mother NGOS. Mother NGOs are to be those NGOs which will in turn support both financially and technically grassroots NGOs which will implement the RCH programmes on the ground. Each Mother NGO will look after a few districts in the state and support grassroots NGOs in those districts. The selection of Mother NGOs is to be done by screening applications by National NGOs as well as recommendations from the local Government authorities. Under this scheme a large number of Mother Ngos have already been appointed in the districts and they in turn are in the process of

identifying grassroots NGOs for implementing RCH projects. For further details regarding the Mother NGO scheme please get in touch with:

Joint Secretary,
Department of Family Welfare,
MOHFW,
Nirman Bhawan,
New Delhi 110001

RESOURCE SECTION

Books And Reports - Some of the books and reports that we found useful in preparing this booklet are given below:

1. Balasubrahmanyam Vimal, "Contraception – As if Women Mattered"; Centre for Education and Documentation, 1986
2. Bell Ruth et al. 'Changing Bodies, Changing lives': A Book for Teens on Sex and Relationships. New York : Vintage Books, 1987 (updated 1998)
3. Bhate Kamaxi et al (eds.), In Search of Our Bodies : A Feminist Look at Women, Health and Reproduction in India. Shakti, Bombay, 1987
4. Billings Evelyn and Ann Westmore, "The Billings Method," Harmondsworth: Penguin 1980
5. Boston Women's Health Book Collective, "Our Bodies, Ourselves: For the New Century"; Simon and Schuster, New York, 1998
6. Burns August, Ronnie Lovich, Jane Maxwell and Katharine Shapiro; Where Women Have no Doctor- A Health Guide for Women; A Hesperian Foundation Book, 1997
7. Centre for Social Medicine and Community Health, JNU, "Reproductive Health in India's Primary Health Care," Delhi, 1998
8. C Sathyamala, Nirmala Sundaram, Nalini Bhanot, "Taking Sides: The Choices Before the Health Worker," ANITRA, Madras, 1986 [Now available in Hindi also]
9. Chayanika, Swatija and Kamaxi, "We and Our Fertility - The Politics of Technological Intervention" (1990) updated 1999, Comet Media Foundation [Original Hindi '*Prajanan: Niyanttran ki Koshishein, Samvad ke Prayas*' 1990]
10. Consortium for Emergency Contraception, "Emergency Contraceptive Pills – A Resource Packet for Health Care Providers and Programme Managers Date??
11. CRLP Fact sheets on Emergency Contraception: CRLP, New York. Date??
12. Ehrenreich Barbara and Deidre English, "Complaints and Disorders: The Sexual Politics of Sickness," New York, Feminist Press, 1973
13. Forum for Women's Health, "Norplant ki Kahani, Auraton ki Jubani; Mumbai, 1993
14. Forum for Women's Health, "Some Thoughts on Clinical Trials," Paper Presented at the Conference of Indian Association of Women's Studies, Mysore, 1993
15. Germain Adrienne and Rachel Kyte, "The Cairo Consensus - The Right Agenda for the Right Time, International Women's Health Coalition,
16. Global Campaign for Microbicides: CHANGE, Washington,
17. Greer Germaine, "Sex and Destiny: The Politics of Human Fertility," New York, Harper and Row, 1984
18. Hartmann Betsy, "Reproductive Rights and Wrongs: The Global Politics of Population Control and Contraceptive Choices," New York, Harper and Row, 1987
19. Holmes, Helen et al., "Birth Control and Controlling Birth: Women-Centred Perspectives," Clifton, New Jersey, Humana Press, 1980
20. Institute for Reproductive Health, "Expanding Options, Improving Access, Natural Family Planning and Reproductive Health Awareness"
21. Jutly Sam, 'Men's Bodies, Men's Selves';

22. Madaras Lynda and Jane Patterson with Peter Schick, "Womancare : A Gynecological Guide to Your Body," Avon, New York, 1984
23. Nair Sumati, "Imperialism and the Control of Women's Fertility: New Hormonal Contraceptives, Population Control and the WHO," Amsterdam, Campaign Against Long-Acting Hormonal Contraceptives, 1989
24. O'Brien Mary, "The Politics of Reproduction," London: Routledge and Kegan Paul, 1982
25. Reproductive Health Matters, "Beyond Acceptability: User's Perspectives on Contraception." Date?? Journal No.??
26. Richter Judith, "Vaccination Against Pregnancy – Miracle or Menace?", Zed Books, 1996
27. Sarojini, Malika and Abha Bhaiya, "*Prajanan Shakti Se Khatarnak Khilwad: Norplant va hormonyukt garbhanirodhak*," Jagori, Delhi, 1994
28. Savara Mira, "Injecting Net En into India," Counterfact No. 10: Centre for Documentation and Education, Bombay, 1986
29. Saheli, "Womantalk – Contraception, Safety and our Health", Delhi, 1994
30. Saheli, "Quinacrine: The Sordid Story of Chemical Sterilisations of Women," A Report, Delhi, 1997
31. Saheli, "Target Practice: Anti-Fertility Vaccine Research and Women's Health" A Report, Delhi, 1998
32. Saheli, "Enough is Enough: Injectable Contraceptive Net En – A Chronicle of Health Hazards Foretold," A Report, 1999
33. Shodhini Network, "Touch Me, Touch-me-not: Women, Plants and Healing," Kali for Women, 1997
34. Summary of the Programme of action of the International Conference on Population Development; ICPD' 94.
35. World Health Organization, Quick Reference Chart on Family Planning Options, Regional Office for the Western Pacific, Manila Date

Videos: There are a large number of videos which deal with contraception or more correctly Family Planning. The Government has also produced a number of these. Given below is a list of films which deals with the issue of Contraception in a critical way.

1. Something Like a War, Deepa Dhanraj: A Film documenting excesses in population control, sterilization and hazardous contraceptives like Norplant.
2. The Legend of Malthus, Deepa Dhanraj: A Film analysing the myths of "over population" propagated by Malthus.
3. The Human Laboratory, Horizon Films: A film about the Anti-Fertility Vaccine and Norplant, documenting the use of women as guinea pigs for medical research.
4. Vaccination Against Pregnancy, Ulrike Schaz: A film about the Anti-Fertility Vaccine and its hazards for women.

Video films, as well as a complete catalogue of available films can be obtained from:

1. Jagori,

C – 54, South Extension Part II,

New Delhi
Tel. 6257015

2. Netwaves,
C/o KP Sasi,
139, 10th A Cross (2nd Floor),
J.P. Nagar, Phase I,
Bangalore, 560 078
Tel. 6553117

Resource Organisations

Resource organisations on Contraception and Family planning are very common. We have tried to categorise these into those which can provide technical information and support and those which provide support for an alternative perspective.

Some organisations from which technical support may be obtained from are:

Parivar Sewa Sansthan (PSS)

This affiliate of Marie Stopes International, is probably best known for its Marie Stopes Clinics and for providing cheap and safe abortion services. But they are also involved in running comprehensive Family Planning programmes in different areas.

Sudha Tiwari, Director,
28, Defence Colony,
New Delhi – 110024
Phones – 011-4617712/9024

Family Planning Association of India (FPAI)

FPAI is one of the oldest NGOs in the sphere of Family Planning and contraception. They have branches in all the states. It usually carries out comprehensive programmes addressing all aspects of Reproductive Health.

Nina Puri, President
FPAI,
Bajaj Bhawan,
Nariman Point,
Mumbai 4000021
Phones 022-2029080, 5134

UNFPA

This UN body is exclusively devoted to the Reproductive Health agenda. They produce a lot of material about the issue, especially related to figures from all over the world.

Michael Vlassoff, Country Representative,
UNFPA,
55 Lodhi Estate,
New Delhi 110003

Office of the **Chief Medical Officer** in every District. They can provide you with information, contraceptives as well as different IEC materials that are produced by the Government from time to time

VHAI and state VHAs

Alok Mukhopadhyay, Executive Director,
VHAI,
40 Institutional Area, Behind Kutab Hotel,
New Delhi 110016

Organisations which are active in promoting an alternative perspective include:

FORUM FOR WOMEN'S HEALTH

FFWH is a campaign group working on women's health. They have been involved with the campaign against hazardous contraception and coercive population control.

c/o Swatija Manorama,

9. Sarvesh,

Govind Nagar,

Thane (East),

Maharashtra, 400 603

Tel. 5423532

JAGORI

This women's group has been involved in documentation on health related issues and the campaign against hazardous contraceptives. Resource material, training material and video films on women's issues and health are also available.

JAGORI

C - 54, South Extension Part II,

New Delhi

Tel. 6257015

Email: system@jagori.unv.ernet.in

SAHELI

This autonomous women's group has been involved in the campaign against hazardous contraceptives and coercive population control since more than 15 years. Issues of ethics in medical research and informed consent have also been raised. Reports, newsletters and other material has been produced in English and Hindi.

SAHELI

Unit Above Shop 105-108,

Defence Colony Flyover Market (Southside),

Defence Colony,

New Delhi 110 024

Tel. 4616485 (Wed & Sat)

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INTRODUCTION

Adolescence is the period between childhood and adulthood. It is a time of rapid change and difficult challenges. The adolescent goes through a wide variety of physical and psychosocial changes. These changes can overwhelm him or her and this phase is often called a phase of turmoil. Unfortunately, by with-holding information about these changes and about different aspects of sex and sexuality from the adolescent an already troublesome phase has become more complicated for many. Further there are added confusions due to the various myths, misconceptions that abound around it, and also due to the stigma attached to the various issues of sexuality.

In India, despite the fact that adolescents form one fifth of the Indian population, their reproductive health needs are poorly understood and ill-served. While the needs of children or pregnant women are acknowledged in national strategies and programs, neither services nor research have focussed on adolescents and their unique health and information needs. In a country where adolescents comprise about 190 million, the health consequences of this neglect take on enormous proportions.

Traditionally the transition from childhood to adulthood among females has tended to be sudden in India. On the one hand, as a result of the poor nutritional status of the average Indian adolescent, menarche occurs later than in other regions of the world. On the other hand, marriage and consequently fertility occur far earlier, thrusting females early into adulthood. Far more social science research is needed that explores why adolescents' sexual and reproductive health service and information needs remain unmet and how health and information services can be structured to respond to these needs, taking into consideration the social, cultural, and economic constraints that adolescents in India face. Non-school going adolescents form a significant part of the adolescent population in India. Their reproductive health needs are magnified because of their poverty and vulnerability for sexual exploitation (e.g. street and working children). There is a pressing need to devise appropriate reproductive health programmes for them, and to make the information and services accessible to such adolescents. The proportion of world adolescent population is rising faster than that of other age groups. An overwhelming proportion of 84% live in the developing countries. In India, of the estimated 190 million adolescents, 8 million 15-19 year olds have experienced pregnancy by 16 years.

In the following pages we shall attempt to define some of the terms used when talking about adolescence and address some of the current issues and debates associated with the subject.

Section One

Understanding Adolescence

Some Definitions

Adolescence

Adolescence is the period between childhood and adulthood. It is defined as including those between 10 and 19 years of age; "Youth" as those between 15 and 24; and "young people" as a term that covers both age groups (WHO/UNFPA/UNICEF Statement, 1989). The Government of India definition according to the draft National Youth Policy (1997) is somewhat different and defines youth as those between 10 and 35 years of age, encompassing the age of adolescence (10 – 19 years) and the age of attainment of maturity (21-30 years)

Puberty

The biological changes that adolescence involves is often called puberty. In this transition dramatic changes occur. There is the adolescent growth spurt caused by rising sex hormone levels. These sex hormones - mainly testosterone in boys and estrogen in girls - also trigger the development of secondary sex-characteristics. Puberty starts in girls about two years earlier than in boys. During puberty a number of physical as well as emotional changes take place in an individual. For example girls and boys both experience an increase in the size of sexual organs and in body height. Ovulation and menstruation starts in girls whereas sperm production starts in boys. An important emotional change is that both boys and girls become conscious of their sexual feelings and themselves as sexual beings. Since society expects girls not to be sexual, a girl may feel guilty about having sexual feelings. Boys on the other hand seek information and experience in a very sly and surreptitious manner, and also end up feeling guilty or confused.

Adolescent sexuality

During puberty, rising hormone levels contribute to an activation of sexual sensations and erotic thoughts and dreams for boys and girls. It has been shown that boys and girls who undergo 'late' puberty (around ages 15-16) generally have less and later teenage sexual activity - including masturbation and intercourse, than boys and girls who have 'early' puberty (around ages 12-13). However, in case of 'precocious puberty' (i.e. when puberty occurs before age 9) there is usually no accompanying change in sexual behaviour. This is probably because the hormonal stimulation alone is not enough to initiate new behaviour patterns without a state of psychosexual readiness that the younger child simply hasn't attained. Sexual fantasies and dreams become more common and explicit in adolescence than at earlier ages, often as an accompaniment to masturbation.

Many adults seem threatened by adolescent sexuality and try to regulate it in illogical ways. There are always excuses for not introducing sex education in schools ("it would put ideas in their heads"), limit information about contraceptive methods, censor what teenagers read or can see in movies ("pure minds, pure thoughts"), invent school dress codes or simply pretend that adolescent sexuality does not exist. But throughout the world the majority of men and women, married and unmarried, become sexually active during adolescence.

Patterns of sexual behaviour in adolescents

Adolescents practice a wide variety of sexual behaviours. The commonest of them being masturbation. Mutual masturbation amongst same sex adolescents is also common. In spite of this there is a huge amount of guilt associated with the activity. Other forms of sexual behaviour include necking and petting which are physical contacts in an attempt to produce erotic arousal without sexual intercourse. Sometimes petting and necking can also lead to orgasm. Sexual intercourse and male and female homosexual relations are some of the other forms of sexual behaviour practiced by some adolescents.

There is not much data available in India about the percentage of sexually active adolescents. Amongst the sexually active adolescents many have single partners, others have more than one partner at a time. Many adolescents enter into a sporadic sexual activity and then keep away from sex. Others indulge in sexual activities regularly. Information about safer-sex practices and its usage is very minimal amongst Indian sexually active adolescents.

Anxiety around pubertal changes

The changes that start in a child during puberty are sudden and intense. Since these changes involve the sexual organs and sexual feelings, the child is not prepared by society to face them. There is almost no source for him or her to seek information about these changes. Talking with parents or teachers is taboo. Peer groups often are ill-informed themselves and tend to give misleading and distressing information, which further mystify the issue. Whatever an adolescent gathers from her/his environment is that these changes involve 'dirty' parts of the body, and this tend to aggravate the problem.

This anxiety is usually there for what are only common pubertal changes. For example nightfall, masturbation or menstrual bleeding can cause severe anxiety in a child. However, if some of these changes are unusual or socially complicated like homosexuality, the anxiety can also drive the adolescent to suicide. There is an immense pressure on adolescents from the middle class and even poor sections of the society in India to work towards securing a job or employment, and all other things, especially the anxiety around pubertal changes take a back seat. These issues are often left un-addressed and can result in poor reproductive health even as adults and affect the personality and relationships of the individual long into adulthood. The adolescent has to face a lot of psychosocial challenges, e.g. becoming independent from parents, developing skills in

interacting well with their peers, devising a workable set of ethical principles, becoming intellectually competent, and acquiring a sense of social and personal responsibility, etc. At the same time that this complex set of developmental challenges is being met, the adolescent must also cope with his or her sexuality and try to adjust it to social expectations.

What is not usually stressed is that adolescence is also a time of discovery and awakening, a time when intellectual and emotional maturation combine with physical development to create increasing freedom and excitement. An unfortunately paradoxical situation arises in the sexual sphere where social norms prevent this natural desire for discovery.

The Generation Gap

During adolescence, movement away from the family continues. Identity formation and developing autonomy are tasks that must be faced during this period. The degree to which an adolescent is able to do this will later affect his or her capacity to develop intimate adult relationships. The task is complicated, because, while adolescents must go through a process of disengagement from their families they still need guidance from their parents. Not surprisingly, parents and young people often have a great deal of difficulty managing this seeming paradox. This issue is raised because parents sometimes feel that their adolescent sons or daughters are beyond the time when they need or will respond to the opinions or wishes of their parents about sexual behaviours. However, adolescents want and need this guidance, and parents need to maintain their own equilibrium during this period and to continue to support their adolescent sons or daughters. This tension between parents and the adolescent is often referred to as the generation gap.

Peer Pressure

As adolescents struggle to establish a sense of personal identity and independence from parents and other authority figures, interactions with their peer group become increasingly important. Teenagers look to each other for support and guidance, vowing to correct the mistakes of the older generations. But they quickly discover that their peer group too, has its own set of expectations, social controls, and rules of conduct. There is a high pressure on the adolescent to conform to the etiquettes of the peer group. Many adolescents are pressurised to smoke, drink alcohol, get into sexual activity, or even into drugs by this pressure. Thus the adolescents' need for freedom is usually accompanied by a need to be like their friends, even though these two needs sometimes conflict.

Peer pressure often works by way of ridiculing the victim. At the least, this peer pressure can make some adolescents feel miserable and inferior if they cannot conform. For example, some boys often brag about sexual exploits with the opposite sex (which may or may not be true), and with girls it can stories about a relationship. Stories of such professed behaviours can make some others of the same peer group feel inferior. Similar pressures can sometimes make a person lose his or her self-esteem and confidence and

can negatively affect his or her personality long into adulthood. The best way to help an adolescent cope with such pressures is through giving him/her proper education on issues such as sexuality, drugs, smoking, etc. as well as on the skills of coping with such peer pressure, and by providing counseling.

Sex education for adolescents

Sex education for adolescents had started in the west many decades ago, but in India it would have been unimaginable a few years ago. Had it not been for the onset of AIDS and the special vulnerability of adolescents and young people, it would never have been even considered. We have still not come to the stage where sex education is implemented seriously even in the big metropolitan cities, leave alone smaller towns and villages. Moreover the contents of sex education leave much to be desired. There is still hesitancy to deal with important sexual issues and emphasis is more on withholding actual information and on enforcing current notions of morality. For example, many policy makers in India are still hesitant to talk about condoms and homosexuality in schools.

Sex education for adolescents is a controversial issue in India. The controversy however is slowly shifting from whether “sex education should be there or not” to the subject areas to be covered in such education, and whether the emphasis should be on anatomic and physiologic facts or on norms and morality. In many cases the name itself is unacceptable and a more sanitised name of Family Life Education is being used. Discussions are also going on about whether regular teachers are best suited for the task or specially trained people should do the job, and whether boys and girls should be taught together or in separate groups. Experiments are going on, on each of these models.

Studies show that adolescents who receive sexual health information and services are more likely to engage in risky sexual behaviour, have unplanned pregnancies or contract an STD. They are more likely to be responsible partners in their relationships, and better able to cope with problems in personal relationships.

Common myths amongst adolescents on sex and sexuality

As there is no legitimate source for an adolescent to seek information and clarification about pubertal changes, and the curiosity is high, the adolescent tries to gather information from peer groups and from pornography both of which provide wrong information. Many myths regarding sex and sexuality have become deep rooted amongst the adolescent. These myths stay with the adolescent for the rest of his/her life and are handed down to the peers and from generation to generation. Some of the more common myths are:

1. Masturbation is harmful.
2. Nightfall is a disease.
3. Sex is a dirty word.

4. Boys are more sexual while girls are more 'romantic'. Some adolescents however believe that girls are more sexual.
 5. Certain activities are made by nature for boys only while others are meant for girls only.
 6. Boys with smaller penises will not be able to give sexual satisfaction to their partners or will not be able to reproduce.
 7. Enlargement of breasts in boys during puberty is a sign of being a 'female' from inside.
 8. Girls with smaller breasts will be less sexual, will not be able to breast feed the baby and will not be able to sexually satisfy her partner.
 9. An intact hymen in a girl indicates her virginity.
 10. Boys who have lesser hair on their face are not men enough.
 11. A girl becomes unclean during menstruation.
 12. One can get pregnant through petting, kissing or anal intercourse.
 13. Withdrawal before ejaculation will not make a girl pregnant.
- And so on...

Section Two

Adolescent Reproductive And Sexual Health In India

As a result of poor nutritional status, menarche occurs relatively late in India; therefore, the biological onset of adolescence, at least among females, may be later in India than elsewhere. On the other hand, marriage and consequently the onset of sexual activity and fertility occur far earlier in India than in other regions of the world, thrusting adolescent females early into adulthood, frequently soon after regular menstruation is established and before physical maturity is attained. Unlike in most other countries, adolescent fertility in India occurs mainly within the context of marriage. As a result of early marriage, about half of all young women are sexually active by the time they are 18; and almost one in five by the time they are 15. Correspondingly, the magnitude of teenage fertility in India is considerable: well over half of all women aged 15-19 have experienced a pregnancy or a birth. In general, the sparse information concerning other aspects of adolescents face a variety of reproductive health problems beyond early marriage and fertility.

Minimum age at marriage - Although India's Child Marriage Restraint Act prohibits marriage below the age of 18 years for girls, its enforcement has been ineffective particularly in traditional societies where child marriage followed by cohabitation is a norm. In such situations often the parents take decisions on behalf of adolescents. While adolescent sexual behaviour, sexual awareness and attitudes remain poorly explored topics, and available findings are not entirely representative, a disturbing picture emerges. The available evidence suggests a significant number of adolescent boys and girls are sexually active before marriage. Sexual awareness seems to be largely superficial. Social attitudes clearly favor cultural norms of premarital chastity. Double standards exist whereby unmarried adolescent boys are far more likely than adolescent girls to be sexually active; they are also more likely to approve of premarital sexual relations for themselves; and they have more opportunities to engage in sexual relations. Both unmarried and married women are vulnerable to being unprotected from pregnancy and sexually transmitted infection. They are also unlikely to have decision-making power in their sexual relationship.

Consequences of early marriage - Adolescents, especially girls lack the knowledge and confidence to deal with sexually transmitted diseases. Even parents are able to do little to help married daughters confront the problem of an infected husband. Pregnancy and motherhood occur to females who are married during adolescence, and exposes them to particularly acute health risks during pregnancy and childbirth. The extra nutritional demands of pregnancy come at the heels of the adolescent growth spurt, a period that itself requires additional nutritional inputs. Any shortfall can result in the further depletion of the already malnourished adolescent. All this can result in severe damage to the reproductive tract, elevated risks of mortality, pregnancy complications, perinatal and neonatal mortality, and low birth weight. Available evidence suggests that maternal deaths are considerably higher among adolescents than among older women. Pressure on

an adolescent girl to conceive may lead to unnecessary medication and premature investigations at the hands of practitioners. Some invasive tests like injecting dyes in the uterus can themselves lead to infertility.

Adolescents and abortion - Information about adolescent abortion seekers is limited, but what is available gives a disturbing picture. Unmarried adolescents constitute a disproportionately large proportion of abortion seekers. Especially disturbing is the fact that unmarried adolescents are considerably more likely than older women to delay seeking abortion services and hence undergo second trimester abortion. This is because of lack of awareness of pregnancy, as well as ignorance of services and fear of social stigmatization. Health consequences of abortion are particularly acute for adolescents. A large number of adolescents suffer complications. Fear and anxiety is also commonly experienced by the adolescent abortion seekers regarding the abortion, their own sexual behaviour and its social implications. Studies have also suggested the vulnerability of adolescent abortion seekers to repeat abortions. Adolescent girls especially for a pregnancy out of wedlock, have to pay much more even at certified MTP centres. This encourages them to resort to cheaper but unsafe alternatives. A disturbing proportion of adolescent abortion seekers become pregnant as a result of rape or non-consensual sexual activity, suggesting the prevalence of violence against adolescent girls.

Adolescents and Reproductive Morbidities- It is far more difficult to deal with reproductive morbidity beginning in adolescence: young daughters-in-law are expected to be fit, robust, and endure high degree of discomfort even while shouldering a heavy domestic work burden. They have little choice about being sexually more active, and also have repeated childbearing ahead of them. Their parental, not marital family are often expected to invest time and money in their medical treatment. These factors make it that much more difficult for them to receive support and proper care.

Adolescents and STDs/HIV/AIDS – As mentioned earlier adolescents in India engage in sexual activity both inside and outside marriage. These relationships could be consensual or coercive. But one fact that is more-or-less universal is the lack of knowledge about safe sex or contraceptive use. Despite campaigns by the Government the knowledge about AIDS is limited especially outside the big cities. This ignorance makes adolescents especially vulnerable to these diseases. Unfortunately there is little hard data available on prevalence figures, but there are evidences from micro-studies that knowledge on these issues is limited.

Adolescents and young people in India Some facts and figures

- 38% women in the age group 15-19 years are married
- 51% of women aged 20 -24 years began their first marriage before age 18
- The NFHS (92-93) indicates that 36% married adolescents (13-16 years) and 64% of those aged 17 -19 years, or 17% of all adolescent females are already pregnant or mothers

- Approximately 7% of married women aged 15-19 years use a contraceptive compared to 21 % in women aged 20-24 years
- Micro-level studies indicate proportion of young females attending STD clinics is increasing
- Experiences of a large service oriented family planning organisation indicates that STIs in the age group 15 - 19 years has doubled over the course of the 1980s

Section Three

Working With Adolescents

Adolescent in India are not a heterogenous group. There are school going adolescents and those who do are non-school going. Some of them are married others are not. Some work, others are non-working. Out of those who work some get paid, many do not. They may be sexually and otherwise exploited. Some are sexually active, while others are not. And of course there are the two distinct groups of boys and girls. All of these groups and sub-groups are distinct from each other. They have different reproductive health and other needs and different values, social codes, aspirations, etc. Anyone wishing to work with adolescents should understand that a reproductive health package which works with one group would not necessarily work with the other. There are different ways of approaching each of these groups. Different organisations work with different groups and sub-groups, specialising in working with their specific target group.

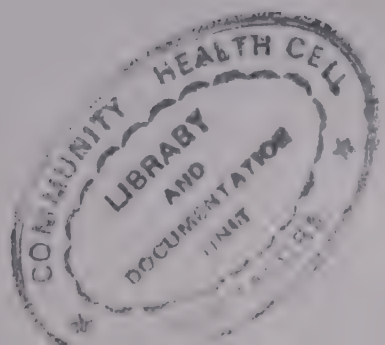
Investing in the second decade of life should be a regular activity at each level of the development community - starting from grassroots NGOs to Government policies. Neglecting young people's health will reduce or negate the benefits of past government expenditures in child survival, childhood communicable diseases, and education as well curtail future economic and social development. Despite their fundamental importance, programs and policies for young people remain lacking. The needs of young people are now only being recognised - often when it is too late - when they become pregnant, need abortions, or are infected with HIV or other STDs. It is time to end the cultural and policy silence surrounding young people's health and prevent young women and men's problems before they start. It is time to devise programs specifically geared towards the needs of the younger age groups.

Issues to kept in mind while devising programme for young people

Risks faced by young people- Low mortality among young people have falsely labelled them as a healthy group. This false impression grossly underestimates the health risks that young people face.

- High prevalence of sexual activity
- Low contraceptive use
- Increasing STI/HIV/AIDS Infections
- Increasing Adolescent pregnancies
- Unwanted pregnancies and pregnancy related complications
- Abortion complications

Barriers to Good health among young people- To understand why young persons suffer from such high rates of reproductive health problems one has to understand the different barriers to good health.



- Low education
- Lack of Information
- Lack of Access- financial, legal, geographical
- Cultural and social restrictions - coercion, unequal power relations, dominant attitudes, lack of decision making power

Recommendations for action

Adolescent health is now being increasingly acknowledged as a area of major concern in international circles. The ripples are also evident in India and the need of the hour is to take bold steps, challenge existing notions and come up with effective interventions. Some ideas which could be kept in mind while designing such interventions are given below.

Ensuring the health of young people is not the sole responsibility of the health sector, but that of the education and employment sectors as well. At the policy level it must be realised that young people not only represent a large section of the population but it is the largest growing section of the population. As such it is necessary to invest in the human capital of youth in order to build a healthy workforce that can not only look after itself but also look after the needs of the elderly, as that group is also going to increase. It is important to **integrate** various efforts that address youth issues to avoid duplication, increase effectiveness and improve cost effectiveness.

The health of young people is directly influenced by and in turn influences their educational status. Schooling for young girls is continually at risk due to various domestic and financial reasons. It is thus essential to provide an environment which provides girls with easy access to good and gender equitable education. Special efforts should be made to address the discrepancy of girls education. Some Government schemes that could be linked up with are the Balika Samriddhi Yojna or any similar State Government scheme.

Provision of **special health care services** for the needs of young people is an aspect which is equally important. This could include simple programmes like health education or sex education, to more elaborate programmes for quality, and confidential abortion services, and counseling.

Last but not the least it must be ensured that young people must be **involved** in the process of planning and implementing the interventions and programmes, so that ownership is built and their crucial insights will help to further align the programmes to their needs.

Suggestions for working with adolescents (Box)

One way to prepare adolescents to cope with this period of turmoil is to give them sexuality education. Here are some suggestions for a sexuality education program which

could be started in schools or even with young people outside schools. Some principles which could be kept in mind are as follows:

1. Individuals yearning for information should be satisfied without imposing a code of model/moral conduct, but more of responsible behaviour.
2. Information, starting from that of the body and its processes should be presented as humanly as possible- without either medicalising it beyond comprehension or sensationalising it. The information should be objective and accurate.
3. It must be remembered that there is no one way of living that can be inculcated in the young. People are different, have different norms and values, and they have a right to choose life-styles which suits them the best, without ofcourse harming others. These classes should promote pluralism and the rich variety of life-styles it entails. They should work for increased tolerance of other cultural perspectives.
4. The sexuality education programme should question traditional gender roles and work towards increased equality between the sexes.
5. It should promote respect for people who have different sexual preferences like men and women who choose same sex partners.
6. The sexuality education programme should not be too negative. Programmes that emphasise too much on warning against having sexual intercourse, against diseases and unwanted pregnancies etc. Create a very negative impression of sexuality. Sexual life is something positive and pleasurable, a source of joy and intimacy – the programme should reinforce this aspect.
7. The program should prepare the participants to establish meaningful relationships.
8. The program should prepare the individual to say no to sex, if they do not want it. They should be prepared to resist all forms of sexual coercion and assault. They should learn that sexual associations of any kind must be voluntary.
9. Single partner relationships with emotional relationship between partners should be encouraged.
10. Individuals should be prepared to cope with peer pressure that can lead them into risky behaviour.
11. The programme should respect individuals and any information that they share must be kept strictly confidential. While participants should be encouraged to share, they should never be forced. The emphasis should be on feeling comfortable.
12. Finally the programme should prepare the young people to take up the challenge of living their lives – as responsible parents and partners, and last but not the least as responsible individuals.

Some Innovative Projects Working on Adolescent Health in the NGO Sector

Adolescent health is one of the emerging areas of work in the NGO sector, and since the sector is emerging most of the work is pioneering and pathbreaking. We have tried to provide an idea of the different kinds of experiments that are being tried out in our country. This is a small and non-representative sample of the kind of work that is being pioneered.

ACTION INDIA, New Delhi

Action India has been working with adolescent girls in urban slums of Delhi since 1990. They have two kinds of organisations of these adolescents – the Nanhi Sabla a forum for 9-12 year olds and the Choti Sabla a forum for 12-18 year olds. Through these fora for a they work on issues like body and menstruation, preparation for marriage, dowry and inheritance, status of girls child sex abuse and so on.

For further details of their work please get in touch with:

Ms Gauri Chowdhury, Director
Action India,
5/27A, Jangpura B,
New Delhi- 110014.

Action Research and Training for Health (ARTH), Rajasthan

ARTH had conducted a survey of rural adolescents in Rajasthan which clearly established that adolescents are extremely vulnerable as far as their reproductive health was concerned, and due to reasons which were primarily beyond their own control. The interventions include community education and clinical services.

For further details kindly contact:

Dr Kirti Iyengar,
ARTH,
67, Adinath Nagar,
Fatehpura,
Udaipur-313004.

Ashish Gram Rachna Trust, Pachod , Maharashtra

Ashish Gram Rachna Trust started its adolescent programme in 1993 because the age at marriage of girls had not gone up in the last fifteen years. Its activities include regular sessions with girls in the age group 9-15, at the village level where topics like personal hygiene, menstruation, puberty, as well as social issues like dowry are discussed. They are also taught skills like rangoli. The programme operates in over 50 villages.

For further details of the programme please get in touch with :
Dr Ashok Dayal Chand, Director,
Ashish Gram Rachna Trust,
Navjeevan Rungnalaya,
Pachod,
Aurangabad, Maharashtra, 431 121.

SWAASTHYA Project, New Delhi

Swaasthya works with adolescents in the Tigri resettlement colony of Delhi. Their work with adolescents started with a study to understand adolescent reproductive health and sexuality issues in the community. The findings of this pioneering study were very revealing and the project is now intervening by providing information and services to adolescents using innovative communication strategies.

For further information about their work kindly contact
Dr Geeta Sodhi, Director
Swaasthya,
Flat-G-4, s-565, Greater Kailash –II,
New Delhi 110048
Email-gsodhi@viasol01.vsnl.net.in

Society for Education, Action and Research in Community Health (SEARCH), Maharashtra

SEARCH initiated its adolescent reproductive health programme in 1995 and the focus has been on sex education. The main method is to hold six –day camps with 50 to 100 boys and girls (separately) where topics like menstruation, reproductive system, forming relationships, relationships etc. are discussed.

For further details about their work please contact-
Dr Rani Bang,
SEARCH,
P.O. and District- Gadchiroli,
Maharashtra-442 605

RESOURCE SECTION

Resource List of Materials

(This list was kindly compiled and supplied by Sagri Singh, Population Council, New Delhi)

ORGANISATION	TITLE & CONTENT	CONTACT INFORMATION
UNESCO- The Regional Clearing House on Population Education and Communication	Adolescent Reproductive and Sexual Health Catalogue: an expanded collection and database on adolescent reproductive health [P/R]*	Carmelita L. Villanueva Chief, Population Education Clearing UNESCO Principal Regional Office for Asia and the Pacific P.O. Box 967 Prakanong P.O. Bangkok 10110, Thailand Tel : 391-0577,391-0686 391-0703,391-0815 391-0880,391-0879 Fax : (662)391-0866
FOCUS on Young Adults	Promoting Reproductive Health for Young Adults through social Marketing and Mass Media: A Review of Trends and Practices [P]	By Ronald C. Israel/Reiko Nagano FOCUS on Young Adults 1201 Connecticut Avenue, NW, Suite 501 Washington, DC 20036 Tel : 202-835-0818
FOCUS on Young Adults	Health Facility Programs on Reproductive health for Young Adults [P]	By Juith Senderowitz FOCUS On Young Adults 1201 Connecticut Avenue, NW, Suite 501 Washington, DC 20036 Tel : 202-835-0818
FOCUS on Young Adults	Reproductive Health Outreach Programs for Young Adults [P]	By Juith Senderowitz FOCUS On Young Adults 1201 Connecticut Avenue, NW, Suite 501 Washington, DC 20036 Tel : 202-835-0818

ORGANISATION FOCUS on Young Adults	TITLE & CONTENT Reproductive Health Programs for Young Adults : School-Based Programs [P]*	CONTACT INFORMATION By Isolde Birdthistle/Cheryl Vince-Whitman FOCUS on Young Adults 1201 Connecticut Avenue, NW, Suite 501 Washington, DC 20036 Tel : 202-835-0818
World Bank Discussion Papers	Adolescent Health Reassessing the Passage to Adulthood [P/R]	The World Bank 1818 H Street, N.W. Washington, D.C. 20433 Tel : 202-477-1234 Fax : 202-477-6391
Studies in Family Planning Vol. 29, #2 June 1998	Adolescent Reproductive Behavior in the Developing World [P/R]	John Bongaarts and Barney Cohen (eds.) Population Council One Hammar skjold Plaza new York, N.Y. 10017 Tel : 212-339-0500 Fax : 212-755-6052
Regional Working Papers No. 7	Watering the Neighbour's Garden : Investing in Adolescent Girls in India [P]	By Margaret E. Greene Population Council, South & East Asia Ground Floor, Zone 5A, Lodi Road New Delhi 110003, India Tel : 464-2901/2902/4008/4009 Fax 464-2903
Implementing a Reproductive Health Agenda in India: The Beginning	Youth : A Resource for Today and Tomorrow [P/R]	By Sagri Singh Population Council, South & East Asia Ground Floor, Zone 5A, Lodi Road New Delhi 110003, India Tel : 464-2901/2902/4008/4009 Fax 464-2903
Implementing a Reproductive Health Agenda in India: The Beginning	Adolescent Reproductive Health : Experience of Community-Based Programmes [P/R]	By Masuma Mamdani Population Council, South & East Asia Ground Floor, Zone 5A, Lodi Road New Delhi 110003, India Tel : 464-2901/2902/4008/4009 Fax 464-2903

ORGANISATION	TITLE & CONTENT	CONTACT INFORMATION
WHO- Adolescent Health & Development Programme Family & Reproductive Health	Action for Adolescent Health Towards a Common Agenda [P]*	World Health Organization Regional Office for South-East Asia I.P. Estate, New Delhi 110002 Tel: 3317802
Network	Adolescents <ul style="list-style-type: none"> • Does sex education work? • The Tragic Cost of Unsafe Abortions • Teaching Teenagers about HIV [P/R]	Family Health International P.O. Box 13950 Research Triangle park North Carolina 27709
Network	Adolescent Reproductive Health [P/R]	Family Health International P.O. Box 13950 Research Triangle Park North Carolina 27709
Population Reports	Meeting the Needs of Young Adults [P/R]	Population Information Program The Johns Hopkins School of Public Health 111 Market Place, Suite 310 Baltimore, MD 21202
Reproductive Health Matters	Talking About Love and Sex in Adolescent Health Fairs in India [R]	Indu Capoor and Sonal Mehta CHETNA Lilavatibai Lalbhai's Bungalow Civil Camp Road, Shahibaug Ahmedabad 380004 Tel : 079-286-8856/6695/5636 Fax : 079-287-6513
International Centre for Research on Women	Adolescent Sexuality and Fertility in India-Preliminary Findings [R]	By Kathleen Kurz International Centre for Research on Women 1717 Massachusetts Ave., N.W. Suite 302, Washington, DC 20036 Tel : 202-797-0007 Fax : 202-797-0020
Tata Institute of Social Sciences	Understanding Sexuality among the Urban Youth : A Study of Mumbai College Students [R]	By Leena Abraham Tata Institute of Social Sciences Deonar, Mumbai 400 088

ORGANISATION	TITLE & CONTENT	CONTACT INFORMATION
K.E.M. Hospital and Research Centre	Adolescent Sexuality and Fertility : A Study in Western Maharashtra [R]*	By Hemant Apte KEM Hospital Research Centre Rasta Peth Pune 411 011
Foundation for Research in Health Systems	Use of Reproductive Health by Married Adolescent Females [R]	By Alka Barua Foundation for Research in Health Systems 6 Gurukrupa, 183 Azad Society Ahmedabad 380 015
Christian Medical College, Vellore	A Study on Reproductive Health of Adolescents [R]	By Abraham Joseph Community Health Department Christian Medical College Vellore 632 002
Youth Sexuality	A Study of Knowledge, Attitudes, Beliefs and Practices Among Urban Educated Indian Youth 1993-94 [R]	By Mahinder C. Watsa Family Planning Association of India Bajaj Bhavan, Nariman Point Bombay 400021 Tel : 022-2874689
Report of an Inter-country Consultation	Strategies for Adolescent Health and Development in South-East Asia Region [P]	World Health Organization Regional Office for South-East Asia I.P. Estate, New Delhi 110002 Tel : 3317802
International Centre for Research on Women (Working Paper No.3)	Adolescent Sexual and Reproductive Behavior -A Review of the Evidence from India [R]	By Shireen J. Jejeebhoy International Center for Research on Women 1717 Massachusetts Ave., N.W. Suite 302, Washington, DC 20036 Tel : 202-797-0007; Fax : 202-797-0020
Demography India 27(1):1998:117-128	Adolescents in Asia : Issues and Challenges [R/P]	By Saroj Pachauri The Indian Association for the Study of Population, c/o Institute of Economic Growth Delhi University Campus Delhi 110007, India
Third party Publishing Company	The Burden of Girlhood: A Global Inquiry into the Status of Girls [R]	By Neera Kuckreja Sohoni

ORGANISATION	TITLE & CONTENT	CONTACT INFORMATION
MAMTA	Adolescent Girl-an Indian Perspective [R/P]*	Dr. Sunil Mehra MAMTA-Health Institute for Mother & House No. 33A , Saidulajab Opp D-Block, Saket, MB Road New Delhi 110030 Tel : 685 8067; 648 5203
WHO- Adolescent Health & Development programme	Coming of Age : From Facts to Action for Adolescent Sexual and Reproductive Health [P]	World Health Organization CH-1211, Geneva 27 Switzerland
Population Council	The Uncharted Passage Girls' Adolescence in the Developing World [R/P]	By B. Mensch, J. Bruce, M.E. Greene Population Council One Hammarskjold Plaza New York, N.Y. 10017 Tel : 212-339-0500; Fax: 212-755-605
The Alan Guttmacher Institute	Into a New World Young Women's Sexual and Reproductive Lives [R]	The Alan Guttmacher Institute 120 Wall Street New York, New York 10005
Family Planning Association of India	Education in Human Sexuality A Sourcebook for Educators [IEC]	By Dhun Panthaki Family Planning Association of India FPAI-SECRT, Cecil Courtn, 5th Floor Mahakavi Bhushan Road Mumbai 400039
Youth Health -For a Change	A Notebook on Programming for Young People's Health and Development [IEC]	UNICEF 73 Lodi Estate, New Delhi 110003 Tel : 4690401
Choose a Future	Issues and Options for Adolescent Girls: A Sourcebook of Participatory Learning Activities [IEC]	The Centre for Development and Pop Activities (CEDPA) 1717 Massachusetts Avenue, N.W. Suite 200, Washington, DC 20036 Tel : 202-667-1142; Fax : 202-332-4

Youth Across Asia

- Country Studies on Youth India, Bangladesh, Nepal, Philippines, Indonesia
 - Workshop on Youth Across Asia-Final Report
- Population Council
Asia & New East Operations Research and technical Assistance Project
53 Lodi Estate
New Delhi 110003
Tel : 461-0913/0914; Fax: 461-0912

P, R, IEC refers to whether the principal focus of the material is Programme, Research or IEC.

Some other books and materials that may be useful:

- CHETNA .1994. Training on Health and Development of Adolescents Report. Ahmedabad: CHETNA.
- CHETNA 1998. Health Education and Development of Adolescents. Ahmedabad: CHETNA.
- CHETNA. 1989. Sowing Seeds of Fertility Awareness. Ahmedabad: CHETNA.
- CHETNA. 1991. We Can, Because We Think We Can: A Report of A camp for Adolescent Girls. Ahmedabad: CHETNA
- CINI. Champa: Reproductive Health Teaching Aids for Rural Adolescent Girls. Calcutta: CINI.
- Gupta, R.B. and S. Joshi .1995. Workshop on Strategy Formulation to reduce Teenage Fertility in Uttar Pradesh. Lucknow: UNICEF.
- K.E.M. Hospital Research Centre. Adolescent Sexuality and Fertility. Pune: K.E.M. Hospital Research Centre.
- Manadhar. T.B. 1998. Education and Adolescents. New Delhi: UNFPA.
- Mehta, S. 1998. Responsible sexual and Reproductive health Behaviour Among Adolescents. New Delhi: UNFPA.
- Ministry of H&FW. 1998. India Country Paper for South Asia Conference on Adolescents. New Delhi: Ministry of H&FW.
- Ramarao, A. 1992. Adolescent Girl Mysteries of Adolescence. New Delhi: Voluntary Health Association of India.
- Singh.S. 1997. Adolescent Girls Programme in India: A Strategy Note. New Delhi: Population Council.
- Swasthya Project. Sexual Behaviour Research among Adolescents in Tigri Resettlement Colony. New Delhi: Swasthya Project.
- Villarreal, M. 1998. Adolescent Fertility: Socio-cultural Issues and Programme Implications. Rome Food and Agriculture Organization of United Nations.

Resource Organisations

The following organisations are involved in working with adolescents either through research or through maintaining documentation centres or by producing material related to adolescent health. They may be contacted for information, materials, trainings or other forms of support. There are many other excellent organisations providing such help and this list can in no way be considered exhaustive.

International Organisations :

UNESCO - The Regional Clearing House on Population, Education and Communication (Asia and Pacific)

P.O. Box 967, Prakanong P.O.

Bangkok 10110, Thailand

Tel - 391-0577-3910686, 391-0703-3910815, 391-0880-3910879

Fax- 662-3910866

Population Council

One Hammaraskjold Plaza

New York N.Y. 10017 USA

Tel - 1-212-339-0500

Fax- 1-212-755-6052

FOCUS on Young Adults

1201 Connecticut Avenue NW

Suite 501

Washington D.C. 20036 USA

Tel - 202-835-0818

Family Health International

P.O. Box 13950

Research Triangle Park

North Carolina 27709 USA

International Center for Research on Women (ICRW)

Contact Person - Geeta Rao Gupta - President

1717 Massachusetts Avenue, NW

Washington D.C. 20036 USA

Tel- 1-202-797-0007

Fax-1-202-797-0020

CEDPA

The Centre for Development and Population Activities (CEDPA)

1717 Massachusetts Avenue, N.W.

Suite 200, Washington, DC 20036

Tel : 202-667-1142; Fax : 202-332-4496

Indian Organisations

CHETNA

Contact Person - Indu Capoor
Lilavatiben Lalbhai's Bungalow
Civil Camp Road, Shahibaug, Ahmendabad- 380004
Tel - 079-2628856/6695/5636
Fax- 079-287-6513
email - chetna@adinet.ernet.in

UNICEF

Lodi Estate,
New Delhi - 110003
Tel : 011-4690401

FPAI

Family Planning Association of India
Bajaj Bhawan, Nariman Point,
Bombay 400021,
Tel: 022-2874689

VHAI

Voluntary Health Association of India,
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**UNDERSTANDING
REPRODUCTIVE HEALTH**

A Resource Pack

Booklet – Nine

Men's Health and Responsibility:

Forging new partnerships

SAHAYOG

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INTRODUCTION

Men's health and responsibility as a distinct area of interest has emerged fairly recently. The interest in men's responsibility and partnership was a logical corollary of the understanding of women's health in terms of socio-cultural factors. If women are powerless and in no position to take decisions which affect their health, improving the health status of women is only possible if the persons who are in a position to do so are involved. In many cases men use their superior social position to consciously make decisions detrimental to women's health, for example, decisions to marry off daughters at an early age, or to inflict violence on partners, or force them into sexual relations. But there are many other situations where men too are ignorant of the health implications of many cultural beliefs and practices that they enforce. A third possibility is that in some situations men too are just victims of societal expectations and enact roles because they know of no other. But whatever be the reason, men still play a vital role in determining the status of women's health, more vitally their reproductive health. And the realisation that substantive changes in women's reproductive health will not be possible without involving men has led to a number of interesting experiments in trying to work with men and forging partnerships.

Reproductive health is not exclusively concerned with the health of women. Though men are in positions of power in relation with women, they are powerless in situations related to their own reproductive and sexual health. What most men possess in terms of knowledge is nothing but myths and misconceptions culled from equally ignorant peers or from pornographic material. Recent research has brought to light the tremendous ignorance of men have in such matters. The demands of being a 'man' also works counterproductively for the health of men in many situations- though many of these linkages are still being explored.

In this booklet we shall try to cover some of the main areas of concern in men's responsibility and their roles with respect to women's reproductive health and in family planning. This is an emerging area of study in the country with a lot of pioneering work being done by both activists and academics. We have also tried to look at men's health independently. As in all other sections we have tried to provide a basic reading list, including the books that we have consulted. We also provide introductions to some of the organisations who have been working on the issue, and who could be provide further assistance on the subject.

Section One

Establishing Men's Role in Reproductive Health

Evolution of the idea of men's involvement

In most societies in India a woman is considered inferior to men and much of her contributions at home, in the fields or even in the workplace are greatly undervalued if not totally ignored. She has little education or mobility and even less decision making powers, even in matters crucial to her health and well being. Women's health activists have been arguing that it is women's subordinate position rather than a cluster of bio-medical causes that has an overwhelming effect on her health. In countries like ours (or for that matter most of so called third world countries) patriarchy is the norm and men wield enormous power and control over women. It is very difficult to secure women better conditions of health within this setup because women's ill-health is a product of the very same situation. As such it becomes essential for strategic reasons to involve men in the efforts of securing better health for women, so that they do not become enemies but allies, as responsible partners and joint decision makers.

Men's Responsibility in Reproductive Health

Today when we talk of Reproductive Health, we can see the need to involve men as responsible partners in every single aspect. The various dimensions of male involvement would start with understanding the politics of socially-defined relations between men and women, and trying to go beyond and redefine them. It would then extend to equal rights within the household and inter-spousal communication, and then into the 'nuts and bolts' of health. Starting from the question of safer sex and responsible sex, this would include looking at illnesses, pregnancy and childbirth, childcare, violence. Given women's lack of decision making, it is crucial for men to emerge as supportive partners of the reproductive choices that their partners make. Further reproductive health problems affect women quite differently from men, even where men are the prime actors. In the case of Reproductive Tract and Sexually Transmitted Infections, for example, it has been recognised that the route is often through the men (husbands), yet while it could be asymptomatic for men, the results can be debilitating and devastating for women (eg. infertility). It is also difficult to ensure improved obstetric care without the involvement of the husband. Moreover, there has also been a growing concern all over the world on the way family planning programmes were only coercively targetting women, which shifted the interest on how to creatively involve the male partner who is equally responsible for the family as his spouse. Further, in the area of domestic/sexual violence, which is an important area of concern for reproductive health, the involvement of men at different levels is crucially important. On a different plane, the empowerment of women is only possible if there is equality, autonomy and respect at home and this needs the active participation and support of the men in the household.

ICPD and Men

The Programme of Action of the ICPD makes a significant point when it tacitly accepts that there is inequality between the sexes and countries should aim at promoting equity between the sexes, human rights and women's empowerment. The ICPD PoA further emphasises that it is not possible to achieve this goal without making efforts to engage men as active responsible partners. It also mentions that information and services have to be equally available to both sexes thus making men's reproductive health a valid subject of interest in the national health agendas. These principles are echoed in the Platform of Action of the Fourth World Conference on Women.

Reproductive Rights include 'the right of men and women to be informed and have access to safe, effective, affordable and acceptable methods of family planning of their choice... Reproductive healthcare programmes should be designed to serve the needs of women, including adolescents, and must involve women in the leadership, planning, decision-making, management, implementation, organisation and evaluation of services. Innovative programmes must be developed to educate and enable men to share more equally in family planning, domestic and childrearing responsibilities and to accept major responsibility for the prevention of STDs.' (ICPD PoA, VII, A)

There is need to 'promote the adequate development of responsible sexuality that permits relations of equity and mutual respect between the genders..' (ICPD PoA, VII, D)

The Need for increasing Men's Role and Responsibility in RH

The need for increasing men's responsible involvement in Reproductive Health has been touched upon earlier. If we agree that there is inequality between men and women and also agree that this inequality has to give way to a situation of greater social equity and empowerment for women, we must involve men. Too many women are poor, too few of them are in positions of power and decision making- starting from the family to the parliaments. Thus social equity and empowerment is essential even for women's reproductive health, because it is only then that they will have the ability to access information, freedom to make choices, to avail services or even to make decisions about their own reproductive health. Women's present position within society is defined by a large number of institutions and traditions- family, culture, religion, laws and so on. Though individual women's effort to redefine their positions within these systems are essential, they are not enough. Men's support and cooperation are essential, because men can play a key role in eliminating inequalities between men and women.

At a more mundane level, neglecting or ignoring men in terms of providing reproductive health related information and services can have detrimental effects on women's health. No amount of healthcare services or preventive information can help a woman whose partner refuses to cooperate with changes in sexual behaviour, practice of safe sex or prevention of unwanted pregnancy. Men's awareness and sensitivity towards reproductive health issues will have to be addressed to bring about any lasting difference in the status of women's health. At the same time, while

addressing men as supportive partners, they will be brought into the wide range of reproductive health services (including information services) as clients in their own right, which will lead to better health outcomes for women as well as men.

It is also important to understand men's sexual and reproductive health needs, which include the need for information and services. Men's own aspirations, fears and concerns deeply affect their behaviour with their partners, and affect the outcome of interventions that target them (such as education about condom use, or encouragement to undergo vasectomy). The preponderance of myths and misconceptions leads to high-risk sexual behaviour (for example, sex with a virgin is a cure for STDs). In fact, men's perceptions about their reproductive problems are usually quite different from bio-medical reality. These aspects need to be researched and models of effective service provision developed, which can then become conduits for disseminating accurate information related to men's role and responsibilities in reproductive health. Service provision will also have to be very carefully designed as men are reluctant to associate with any stigmatized images in seeking reproductive healthcare, such as going to the "Venereal Diseases" department in a hospital.

It is also important to understand that men are socialised into stereotyped notions of how they should behave from adolescence, so any interventions at changing their socially constructed behaviour should start with emphasis on the early years. Moreover, adolescents themselves have special needs for reproductive health information and services. Despite being sexually active, they are not socially permitted to seek information from legitimate and accurate sources.

Men's knowledge of and involvement in women's health and family planning

While men's involvement is a very desirable goal, reality is far from such a situation. A few studies have been conducted which have tried to understand what the situation is at present. The finding from these studies more or less confirm the assumptions that men are not very involved, don't know too much about their partners health, and that communication on reproductive health between men and women is very limited. Some of these findings are presented below, but it must be mentioned that these findings have been collated from a number of studies and only provide a flavour of what the situation is in different parts of the country.

- there is a major lack of communication between the husband and the wife on their reproductive goals and acceptance of contraception. Whenever it occurs it is initiated by the husband, and only after 2 or 3 children.
- many men believe that reproduction is a natural process and does not need to be discussed, most believe that discussions on these issues should always be initiated by men and about a third felt that they would be offended and would react adversely if their wives took the initiative to discuss either reproductive goals or contraceptive use.
- most men are aware of vasectomy, tubectomy, pills and condoms, but the use of contraceptives for spacing is still an alien concept.
- men prefer tubectomy to vasectomy because they feel its simpler and the latter requires more rest and makes them weak, whereas they have to earn a living.

- Fathers' participation and even the expectation of mothers in bringing up children is limited
- knowledge about care in pregnancy and delivery is limited.
- men's knowledge of the female reproductive system including menstruation is very limited
- men get to know of women's illness only when she tells him or when household work gets disrupted
- men often do not accompany wives to the clinics when she goes to seek treatment because it could mean loss of wages or affect employment
- men do not think that their involvement in women's health is very important or necessary
- most men are ignorant of the specific illnesses of their wives or women in the family but have some idea what women's illnesses are
- some men own up to physically abusing their wives, having sex while she is unwilling and using physical force for doing
- an interesting finding in a couple of studies has been that men are aware that women fall ill more, and this is due to the fact that women have to do more work or face greater hardship.

(From papers presented at the **Population Council** workshop on *Men as Supportive Partners*, 1998, Nepal.)

If the situation seems very dismal it is because the above is a collection of findings from a few different studies and does not represent the situation in any one particular place.

Increasing men's responsibility

Increasing men's responsibility in the Reproductive Health of women, begins by examining and defining their roles and responsibilities within the family unit. The man is usually supposed to be the bread-winner and the head household, and most care-giving functions are supposed to be delegated to the women. This construct prevents men from engaging in positive roles in reproductive health matters. This dichotomy has to be re-examined and this can begin with the realisation of the different economic contributions that women make to the household in addition to their accepted care-giving roles. Men need to realise there are several ways of care-giving in the different roles that they occupy in the family- father, husband, brother or father-in-law. New ideals will have to be defined for these roles. But this is not going to be an easy task as this involves a lot of unlearning on the part of individuals and considerable resistance from existing social norms and traditional notions both among men and women. Appropriate institutional mechanisms do not exist in most workplaces to encourage men to adopt these new roles (paternity leave) and then the individual is vulnerable to ridicule from peers. Finally there are not enough roles models or prescriptions available which men may adopt. For a start, an indicative list of different responsibilities men may adopt as caring partners, or as fathers for example, is given below.

Men as Sex Partners

1. Sex should not be seen as a sole male prerogative and should not be forced upon the partner. Adequate attention has to be paid to foreplay and to emotional aspects

of sex.

2. Take responsibility for safe sex, rather than putting the onus on women
3. In case of an infection (like STDs), getting immediate and reliable treatment and avoiding sex until fully treated
4. Men should support the reproductive choices made by their partners regarding the number and timing of children
5. Care of partner during pregnancy and after childbirth, especially diet and rest. This could mean helping with housework and childcare
6. Being sensitive to his partner's reproductive health problems, support in preventive hygiene and getting early treatment, and in case of infections, also undergoing the treatment personally

Men as fathers

1. Planning for daughters to have adequate education rather than being obsessed with thoughts of their marriage
2. Ensuring that daughters are at least eighteen, and preferably older when they do get married.
3. At marriage, monitoring whether the daughter will be treated with dignity, rather than doing financial tradeoffs
4. Supporting the daughter when she expresses discomfort with her husband's family rather than trying to send her back there.

However, all these are dependent on men themselves receiving accurate information, both about their partner's bodies and health as well as about their own. At present this is not the case, for men are prey to misinformation, and suffer almost as much as women from uncertainties and anxieties about their own reproductive health and sexual behaviour. Men's problems are also shrouded in secrecy as "Gupt rog" quite like the culture of silence that surrounds women's gynaecological problems.

Moreover, it is imperative for men to renegotiate the spaces that society has granted to them in terms of relationships with women, and care of women's bodies. At present men are unable to publicly express concern for their women partners as it would be taken as a sign of weakness. Neither would men be expected to participate in pregnancy and childbirth or post-partum care of their partners. As such, men are reluctant to enter the so called "women's domains" partly because of family and peer pressures. This makes the whole question of male responsibility in women's reproductive health extremely complex.

There is also the whole question of dealing with men who are perpetrators of violence against women. It is common understanding in current feminist discourse that such men may not be differently categorised (and therefore excused, and other men excluded) as being social aberrants. As such they are apparently "normal" men who exhibit their sense of power and aggression through perpetrating violence against women. The question is, can we intervene at some stage in the life cycle of a male to ensure that he will not become a perpetrator? Can we get all males to take collective responsibility for violence against women (rather than dissociate themselves from it as aberrant behaviour), and to work collectively to stop this from happening? How will this be done? These are some of the very real questions facing those who work with sexual and reproductive rights of women, and there are no easy answers.

The Health System in India and Men's Involvement

Reproductive Health is a term that has gained currency in India only after the announcement of the RCH programme in October 1997. To many within the establishment it still means little and is seen as a new name for the earlier Family Planning Programme. The Family Planning Programme was heavily geared towards targets for female contraceptives. There was no concept of addressing men as responsible partners. The infamous excesses of forced vasectomies during the Emergency in 1977 and the consequent political fallout seemed to have made service providers averse to addressing men for contraceptive services and education. Coercive methods were used to meet year-end targets, and women were much easier subjects. Other than the mandatory advertisements for vasectomy and some training of doctors in no-scalpel vasectomy, not much has been done to creatively involve men in the entire process. Using their own cultural biases about men's roles and responsibility the programme planners have ignored the potential to involve men not only in contraception but the care of women or in family planning decision making. Overall the entire health and family planning programme have only reinforced traditional stereotypes where male involvement is concerned. A small change seems to have been started with the Target Free Approach in Family Planning which actually tries to use Male Workers to address men for family planning information and services. It is hoped that this provision will provide the appropriate impetus in the right direction.

As far as women's illnesses are concerned, the most easily available healthcare providers - male doctors, have all been brought up on an exclusively biomedical version of health. Hardly any in our health system are trained in a gender-sensitive manner. They are products of a very patriarchal society and this reflects in the way they treat their women patients. Most of women's complaints are considered vague and often attributed to imagination. Women doctors (who are often as gender insensitive as their male counterparts) are seldom available outside big hospitals and cities, and male doctors are left to deal with women patients with little understanding of their social situation.

Section Two

Men's Health

Men's Health as distinct from Men's Responsibility

While men have started off with the disadvantage of being the party in power and the perpetrator of the inequalities, health relates to individuals while systems (patriarchy) breed the inequality. And individual men are often as much victims of the system as with women. Recent research is throwing up evidence that the individual man is often as ignorant, ill-informed, powerless in the face of role expectations and vulnerable as women are. AIDS has been responsible in many ways for generating this interest in men's reproductive health. Earlier, what most men had for their own reproductive and sexual health were myths, gossip and quackery. Considering this situation it is equally important for practitioners to consider the entire issue of men's health distinctly from that of their responsibility alone. Of course, there is one school of thought that is of the opinion that in the current scenario, where the state of women's health is abysmal, it would divert attention and resources from an area of far greater priority. Some argue that focussing attention on men's need may in fact worsen the power situation between men and women.

Men's health and its social determinants

In the socio-cultural model of health (as opposed to the biomedical model) it has been clearly established, that health and illness are greatly influenced by cultural values and practices, social conditions, and human emotion and perception. As has been elaborated elsewhere, women's health is to a great extent related to her situation at home and the powerlessness that she has to deal with. This acknowledging of women's social situation as a determinant of health was the result of rigorous work by feminist researchers and by the late 1970s epidemiological researchers in the West (those who are concerned with the incidence and causation of disease) had begun to include 'gender' as a variable in their work. But until recently researchers have tended to equate the study of gender and health to studies of only women's health and illness.

If the use of the term gender and health is not to be restricted to women's health alone, it leads to the question that does 'being men' also affect the health of men. Descriptive research findings about the differences in men and women in terms of health and illness (in the West) have revealed that:

- (a) men experience more life-threatening illnesses and die younger than women
- (b) women experience more non-life threatening illnesses and live longer than men
- (c) women see doctors more frequently than men (not in the context of childbearing).

Feminist theory attributes the situation in women to their additional burden of ill-health to power differences between the sexes, in addition to gender identity, socialisation and conformity to role expectations. But does this also mean that men because of their social position are healthier as a whole and when they have an illness, it tends to lead to their death? There are a number of diseases which show greater incidence in men, but is that preponderance biological or is it social? Many of these questions do not have definitive answers, and the area of knowledge concerning the situation in India is relatively unexplored.

When discussing about men's health, it would also be erroneous to deal with men as a undifferentiated group. The study of men's health and illness needs to somehow address the differential exploitation of the lesser-status, marginalised male subgroups (e.g. men of lower castes, poor men) in the changing social order. For example the life chances of prison inmates and college students, rich businessmen and rural dalit men, straight and gay men, and professional men and homeless men are clearly different. Analysis of men's health, needs to be sensitive to these differences in men's lives and explore the relationships between men's social situation and their health in a very holistic manner.

What needs to be done

The study of how social situations especially gender relations influence men's health and illness is at an early stage of development. Early research indicates that men's health seems to be one of the areas in which the damaging impacts of traditional masculinity are evident. More and more social scientists, medical researchers, public health advocates, and men themselves need to be mobilised to decide to think about and investigate these linkages thoroughly as well. In fact an alternative discipline of men's health studies has slowly begun to emerge in some parts of the world. Part of the mission of men's health studies, is to carefully research these linkages and to discuss them with professional audiences and the general public. The socio-cultural model for understanding men's health and illness needs to be placed in the backdrop of power relations as well. This means lending weight to feminist theoretical insights that social inequality irrevocably influences women's and in this case men's health as well, and that differences in political and economic power yield differential health effects/outcomes.

In order that things change men need to start with personal change. But this change in men will not be possible without their changing the political, economic, and ideological structures of the present gender order. And to start at a personal level men need to challenge their own long held notions of 'being a man' and they need encouragement, positive role models and the space and sense of security to do so. Personal change needs to be reinforced by structural and institutional changes as well. To point to a very common situation in India- when a man decides to go in for a vasectomy, the doctors and nurses first ask the man why is he doing so, is his unable to get his wife's sterilisation done? If men are going to take up the challenge of understanding their own behaviour and in some ways to tackle their own health, they need to set out on a course which may be called pro-feminist because it not only seeks to redress the oppression of women by men but also the oppression of lesser-status men by privileged males within the inter-male dominance hierarchy.

Men's Socialisation and their Health

The social, cultural, and political dimensions of illness have been strikingly evident in the AIDS epidemic (Shilts, 1988). Survey researchers have been generating useful information about how men's sexual practices, attitudes and risk behaviors are linked to the growing AIDS epidemic. For men, especially gay and bisexual men, who are infected with HIV virus, the myriad of meanings associated with AIDS steep into their gender and sexual identities. In an analysis of interviews with 45 HIV+ gay men Richard Tewksbury provides insights into how masculinity, sexuality, social

stigmatization, and interpersonal commitment mesh in the decision making around risky sexual behaviour. In another American survey of boys between 18-19yrs, traditional attitudes (towards how a male should behave) were also associated with such acts like- ever being suspended from school, drinking and use of street drugs, frequency of being picked up by the police, being sexually active, number of heterosexual partners in the last year, and tricking or forcing someone to have sex. Such behaviours which are in part expressions of the pursuit of masculinity, elevate boys's risk for STDs, HIV and early death by accident or homicide and also result in oppression of women by men.

Boys learn to separate themselves from others and evaluate themselves and others according to status because they strive to fit into male dominated, hierarchically organised institutions such as marriage, sports, government and business. Hence male psychology or gender identity derives from and revolves around status and power differences between the sexes and among men. Another finding with patients of testicular cancer vividly demonstrates the potential benefits of more flexible conceptions of manhood for men themselves. Those who coped with it in a traditionally masculine fashion had great difficulty in dealing with their situation while those who tried to define a new conception of manhood found meaning and emotional health.

Masculinity

The meaning of being 'male' differs in different cultures and groups there is something often mystical associated with the masculine identity. This identity is different from just the anatomical maleness and is a condition which boys aspire and have to achieve. Researchers have varied in the ways that they have conceptualized and measured masculinity. Robert Brannon (1976) identified the following four major components of the male role:

1. The need to be different from women
2. The need to be superior to others
3. The need to be independent and self-reliant
4. The need to be more powerful than others, through violence if necessary.

The strong need to be different, and being superior also leads to a sense of insecurity and many theorists are of the opinion that this sense of insecurity leads their violence over women. While these findings relate to the western situation, they may be compared with the situation of men in our society as well.

Gender socialization influences the extent to which boys adopt masculine behaviors, which in turn can impact on their susceptibility to illness or accidental deaths. Research in the West (which is the what we have to go by today) has shown that a 'give 'em hell' approach to life can lead to hard drinking and fast driving, which account for about half of male adolescent deaths. The need to be a sturdy oak and to avoid any resemblances to feminine dependancy may account for the tendency men have to deny symptoms of coronary heart disease. In the world of bodybuilding subculture, where masculinity is equated to maximum muscularity and men's strivings for bigness and physical strength hide an inner core of insecurity and low self-esteem. Bodybuilders often put their health at risk by using steroids, over-training, and engaging in extreme dietary practices.

When strength and physical ability are key components of this kind of 'being superior' masculinity, men with physical disabilities experience considerable difficulties constructing a workable masculine identity. On the one hand, they struggle to cope with stigma and feelings of inferiority, whereas, on the other hand, they strive to redefine masculinity in ways that circumvent, transform, or reject dominant cultural definitions of manhood. Sex role theorists agree that the social construction of masculinity in the American gender order produces negative impacts on men's health. Therefore it follows that men in the new millenium have a vested interest in challenging the traditional gender roles and timeworn notions of masculinity that have proven dangerous to their health.

Men's Reproductive health

Men's reproductive is one area of men's health which has been investigated to some extent in recent years. A number of studies have been conducted in order to understand how much men are aware of their own reproductive and sexual needs. The findings from these studies have uniformly revealed a rather grim situation. Men have little or no information about their own bodies and its needs and in the case of serious illnesses too serious myths and misconceptions abound.

Box-

The following observations were made by the group TARSHI which provides counselling in the field of reproductive health. TARSHI operates a telephonic helpline meant initially for women but it is accessed more by men.

- more men are concerned about sexual issues, and reproductive issues including contraception for them comes later.
 - in the area of sexual and reproductive health men have a need for information about how the body functions, how to deal with their sexual problems and how to avoid conception and infections, in that order of preference.
 - basic sex information queries include those on masturbation, nocturnal emission, male genitals, sexual techniques and positions, breasts, female genitals, anatomy, semen, male and female homosexuality, etc.
 - men's concerns about sexual pleasure have more to do with their own pleasure and less with pleasuring their partners.
 - with regard to conception and contraception men ask about contraceptives and search for an "easy" contraceptive. A large number of men do not know how to use a condom properly.
 - Some men especially those in their first sexual relationship, seem surprised that conception can occur at any time. Many have heard of "safe days" but the information they have is inaccurate and leads them often to have sex at the time the woman is at her most fertile.
 - many men speak about infertility and emotional problems which disapproves the myth that it is generally women who are troubled by these issues.
 - a lot of socially reinforced myths and misconceptions and deep-rooted attitudes abound. e.g. most males grow up believing that a loss of semen by any means apart from intra-vaginal ejaculation leads to a "loss of strength". These myths and attitudes shape and influence sexual activity, contraception, gender relations and the enactment of violence in sexual relationships.
- (from- Chandiramani R. (1998) Men on the Line; in papers presented at the

These and similar findings from other studies clearly underline the fact that men have literally been 'hiding' behind a façade of power and authority, where in actual terms their ignorance and understanding of their as well as women's bodies and their processes is as incomplete as that of women. This ignorance leaves men also vulnerable to number of diseases and conditions. There is an urgent need to devise ways in which men, especially adolescents can access accurate information about such issues. This will not only lead to their able to negotiate their own sexual experiences in a more responsibly. It may also be argued that the responsible sexual behaviour of men will indirectly benefit their sexual partners (women) too.

Reproductive Health Problems of Men

The main problems or conceived reproductive and sexual health problems faced by men in India, as shown by a couple of studies conducted include *Hashtmaithun* (masturbation), *Kamjori aur namardi* (impotence/ lack of sexual desire), *Shighrapatan* (premature ejaculation), *Dhat Girna* (White discharge from penis), *Tedhapan* (bent penis), *Khujali* (Itching), *Dane* (boils), *Peshab me Jalan* (burning urine), *Dhat patla hona* (thinning of semen) *Garmi* (heat inside the body) and so on. It must also be mentioned that the terminology used is often used to indicate a range of symptoms and the corresponding medical term may often be difficult to locate. Also, often times a problem is also perceived as a reason. Thus masturbation or *garmi* can be seen both as a problem as well as a reason for a problem. What comes through from these studies is that the terminology used to describe men's problems is very contextual and has to be understood and interpreted carefully. Myths and misconceptions abound and the reasons for many of these illnesses are often attributed to practices like going to a public toilet, indulging in excessive masturbation or even pornography. These reasons are far from being bio-medically correct but are deeply entrenched in men's minds because the source of health information for men are often unqualified practitioners or traditional healers

Health seeking behaviour and service providers for male reproductive health problems

As is evident from the above sections there is a tremendous amount of ignorance on matters relating to sexual and reproductive health. This has been a taboo subject for centuries. In the absence of right information, myths and misconceptions abound. And since there is no place people can turn to if they need sexual information or if they have a sexual or reproductive health problem, many unscrupulous people make use of this situation and offer false and ineffective treatments or wrong information and often harmful drugs. They charge from a few rupees to thousands of rupees for their services depending on the clientele they are catering to. Such unscrupulous practitioners abound even in metropolitan cities like Delhi where thousands seek what could be termed as bogus treatment for a range of sexual problems (including what is perceived to be a problem by the individual but is completely normal). For example one can easily find posters all over cities or on walls around highways or railway tracks, proclaiming to offer guaranteed relief from nightfall, premature ejaculation, impotence, *Dhat*, and so on.

Another common sight in India is that of street hawkers selling various kinds of preparations as remedies for sexual problems or as aphrodisiacs. Some of them are made out of questionable ingredients. Some of these preparations are extremely cruel to animals, e.g. *Sande ka tel* which is prepared in front of the onlookers. Live *Sandas* an endangered species of lizards, are boiled in a container. The liquid is then sold as an aphrodisiac which will prolong the duration of erection.

There is hardly very little information available about what kind of people run these services, what kind of treatment they offer, who are the people who visit them and so on. But hopefully things are changing now AIDS awareness campaigns have brought discussions on sex and sexuality out into the open, at least in some sections of the society. The Government on its part has renamed the infamous 'VD' clinics into clinics for RTIs and STIs and the new RCH approach makes it mandatory for each district to have one such clinic if not at each Community Health Centre. There are also guidelines on how much space such a clinic should have. If this clinic approach can be complemented by an effective health education campaign, one may expect that men will slowly stop visiting unscrupulous clinics furtively and seek proper medical advice for their problems.

Some of the important Reproductive Health problems of men

Infertility: This is an issue of concern because in many communities where a woman fails to conceive within a short period after marriage she is held responsible and has to suffer great mental and often physical harassment within the household. It was a common practice in the past for men to marry again in such a situation. Male infertility needs to be recognised and efforts made to involve men in cases where women fail to conceive. Male infertility can be due to various reasons. The most important of which are a low sperm count or low mobility of sperms.

Testicular Cancer: Testicular Cancer occurs most commonly between the ages of 15 and 40 years, though it can also occur in infancy and late adulthood. Individuals who have had an undescended testicles are at higher risk of developing testicular cancer. The best way to diagnose testicular cancer is through self-examination. The usual initial finding is a painless lump in or on the testis, a hardness or enlargement of the testis. Less commonly there is associated pain and tenderness or bloody discharge. Testicular cancer has one of the highest cure rates of all cancers. The treatment includes surgery, radiation therapy, chemotherapy or a combination of these.

Box-

Testicular Self-examination

Testicular self-examination is an important part of routine health of men and should be done once a month.

Gently grasp the testicle between the thumb and index finger using both hands. Roll it between your fingers applying a small amount of pressure in an effort to detect any irregularities of the surface or texture of the testis. After one testis and chord has been examined one can then examine the opposite side. Often comparing the two sides can help establish an abnormality in one side or the other.

Fortunately most scrotal or testicular masses are not cancer, but nevertheless one should immediately see the physician.

Variocoele - Variocoeles are enlargements of the veins that drain the testicles. Some variocoeles may cause pain and/or testicular atrophy (decrease in size). A variocoele affects fertility due to the decrease in circulation of blood in the testicular area. Many cases are diagnosed during an infertility checkup. It can be cured through a surgical process.

Hydrocele - A hydrocele occurs when fluid fills the membrane covering the front and sides of the testicle and epididymis in the scrotum. This is usually not painful, but is often uncomfortable due to the increased size of the scrotum. Possible causes are: trauma to the scrotal area or inflammation or infection of the epididymis. Some hydroceles need not be treated as they resolve without intervention or remain asymptomatic. When a treatment is necessary, the best intervention is *hydrocelectomy*, surgical correction of hydrocele under anesthesia. Where surgery is not recommended because of health etc. reasons the hydrocele may be aspirated. Aspirated hydroceles may reappear. Filariasis is one of the common causes of hydrocele especially in endemic areas.

Prostate Cancer

Prostate Cancer usually occurs after age 55. Most patients are 65 years or older. In its earliest stage this cancer may not produce any signs or symptoms. As the tumour grows one may experience:

- difficulty in starting or stopping urinating
- decreased strength of the urinary stream
- dribbling at the end of urination
- painful or burning urination
- frequent urination, especially at night
- painful ejaculation
- Blood in the urine
- An inability to urinate
- Continuing pain in the lower back, pelvis or upper thighs

Early detection of prostate cancer increases the chances of a cure. Treatment includes surgery, radiation therapy, hormone therapies and cryotherapy (which freezes the prostate and the appropriate nearby tissues).

Sexual health problems like Masturbation , Impotence , premature ejaculation are being separately dealt with in the Section of Sex and Sexuality.

Section Three:

Starting a Programme for Men and Reproductive Health

Important Imperatives

Realising the importance of involving men in reproductive health programmes as well as the need for sensitising men to their own needs and offering them appropriate services a number of organisations have initiated such pioneer efforts. Some of these efforts are being briefly touched upon in this section. There are a few organisation which has been doing pioneering work with male clients in family planning for a long time all over the world. Experiences gained in one country are being tried out in others. Some of the key elements of different successful programmes concerned with men and reproductive health are outlined below.

Gender concerns - Gender is a fundamental context for work with both men and women, as it shapes all aspects of clients' lives. Gender issues, which are inevitably culturally specific, are a crucial consideration in program design. The program should ensure through trainings that the staff is gender sensitive. The information about the pressing gender concerns in the community should be procured through various levels of community sources and addressed in programme design. It is helpful to form linkages with other existing services in the community to ensure that the program is able to address issues like gender-based violence.

Access to services - Reproductive health services must be made accessible to men. The program may have to overcome cultural biases to achieve this. If possible men should be provided service separately (from women), but if it has to be integrated with women's services it should not compromise resources for women.

Service Selection - One very important consideration in program design is determining what reproductive health services should be offered to men. Such services should include physical exam, referrals, comprehensive reproductive health education, education and counselling for contraception and STDs and genital health and hygiene.

Sustainability - Program designers should plan for future economic and technical sustainability from the very start of the program. For this the services should be tailored to what the community wants and needs. One way to do this is to start a program by asking community members to articulate their needs and brainstorm about priorities to meet them. The program should be cost conscious. The possibility of cost sharing with other organisations and cost recovery could be considered. The use of existing labour pools -- e.g. medical, public health students who might provide labor at a reduced cost, could be investigated. It is also helpful to garner necessary political and other appropriate high-level support.

Community Outreach and Workplace Programs - Information and education should reach potential clients outside as well as inside the clinic setting, for example at workplaces or in places where clients spend their leisure time. Reproductive health education can be incorporated into existing school-based and other training

programmes (e.g. military or police training). Informational meetings can be arranged IEC materials distributed during community events, such as local festivals. Employers and managers should be involved in introducing and supporting the program.

Counseling - Men have special needs when it comes to counselling for family planning and reproductive health. Counselling requires respecting each client and tailoring advice to suit his or her individual needs. All counselors should be good listeners and communicators who are both non-judgemental and knowledgeable.

Integrating STD Services - Reproductive health services should include HIV/STD education, prevention and treatment. The issue of STDs may present special challenges, for example, there may be a great social stigma attached to talking openly about these issues. The programme should lay emphasis on prevention, including safer-sex and proper and regular use of condoms during sex. It should also help providers deal with values and biases related with STDs and HIV/AIDS. Education and counseling are important to help behavior change. Clients should be encouraged to be community educators.

The special need of adolescents - To meet the special needs of adolescents setting up accessible youth centres can be very helpful. Skits and other forms of arts can be used to raise issues and direct young people to services. Providers should be trained to talk to and deal with young populations. They should be sensitive to the special concerns of youth (physiological development, sexuality, peer pressure, etc.). Peer educators and counselors also play an important role.

Publicising Services and Attracting Clients - When trying to attract male clients to new or expanded services, male-specific information, materials, and counseling must be provided. By making use of mass media etc, providers can reach a larger audience and can stimulate awareness as well as change mindsets and attitudes. Such messages should be in a culturally sensitive manner. Well known local groups can be asked to endorse such messages.

Agenda for Research - While these are some of the strategies that have been tried out for involving men, these are still far being being universally applicable. There is need to refine and make these more effective. Towards this end there should be more research for testing the efficacy of the strategy of men's involvement in reproductive health. Research should also be directed towards understanding family dynamics and roles of various actors including the society in decision making process vis a vis woman's reproductive health. This will enable such programmes to be even better planned and focussed.

Some of the organisations working on men's health and involvement

1. SARTHI

Social Action for Rural and Tribal Inhabitants of India, is a registered society working for integrated rural development in the Santrampur *Taluka* of Panchmahals district in Gujarat (working in 150 districts). Much of the population consists of marginal farmers who are dependent on rainfed agriculture and who also have to migrate seasonally. The range of programmes include: installation of hand pumps for drinking water, agricultural improvement, wastelands development, education through non-formal schools, rural industries for income generation, development of alternative energy sources, women's development, and awareness generation.

Driven by demands to add reproductive health services for men, SARTHI has been running a Community Health Programme (CHP) for men (note: it says general community health programme but it seems only for men). Currently, male health workers run general clinics under CHP in about 60 villages. They are trained to treat the common problems in the community as middle level health and multi-purpose workers.

Address: Sahaj/ Sarthi, 1, Tejas Apartment, 53, Hari Bhakti Colony, Old Padra Road, Vadodara-390 015, Gujarat; Tel: 0265-340223, Fax: 0265-330430.

SARTHI- Godhra

Contact Person: Renu Khanna, Harish Patel, Balwant Pagi and Nirmal Singh.

2. Deepak Charitable Trust

This trust was established to provide health care services to the communities around the industries. They are involved in a wide range of activities including various community health and rural development projects as well as women's empowerment and information, education, communication. It aims to achieve the goal of small family norm by providing services for safe motherhood, child survival and providing family life education to adolescents.

The Deepak Charitable Trust has started a *Pati Sampark* programme to involve men in the antenatal care of women.

Address: Deepak Charitable Trust, Deepak Medical Foundation, 9/10, Kunj Society, Alkapuri, Baroda - 390 007, Tel: 0265 339410/ 331439, Fax: 0265-330994; E-mail: dnl.alakhani@dnl.sprintpg.ams.vsnl.net.in

Contact person: Ms. Aruna Lakhani, Co-director of Deepak Charitable Trust

3. SEWA Rural

Society for Education Welfare and Action - Rural is a voluntary service organisation working for health and rural development in a tribal region of Bharuch district, Gujarat. Its work includes running a community hospital, outreach health care through Community Health Project, comprehensive eye care programme, a technical centre for rural youth, tutorial classes for potential school dropouts, and income generating activities along with saving and awareness programmes as part of women's development.

The society has adopted different strategies over the last few years to reach out to men in order to enhance their roles and responsibilities in women's health. This includes sensitisation and orientation of male (and female) health workers, male members of the family, etc.

Address: Sewa Rural, Jhagadia 393110, Dist. Bharuch, Gujarat; Tel: 02645-20021.

4. PSS -- Purush Clinic

PSS, a registered voluntary organisation has been working in the field of maternal and child health and Family Welfare in several states since 1978. PSS is affiliated with the British charity Marie Stopes International which encourage and support family planning programmes in many developing countries all over the world.

It has set up a branded male clinic called *PURUSH* - Male only clinic in Chennai, Tamil Nadu. It offers an integrated package of services for men with special emphasis on family planning.

Address: Parivar Seva Sanstha, C-374, Defence Colony, New Delhi-110 024, Tel: 4617712/ 4619024, Fax: 4620785, E-mail: pssindia@viasdl01.vsnl.net.in

Contact person: Ms Sudha Tewari, Managing Director, PSS

RESOURCE SECTION

Further Reading

Some of the books which we found useful in the preparation of this booklet are given below.

- Akhter H.A. 1996. Male Contraception. Dhaka: BIRPERHT
- Amin A, et al. 1996. Men's Perception of illness of the Nether Area. Gujarat. SARTHI
- Amin A, et al. 1997. Attitudes and behaviours of Men in Relation to gender and sexuality. Gujarat. SARTHI
- AVSC International 1997. Men as Partners in Reproductive Health: Workshop Report. New York.
- AVSC International 1997. Programming for Male Involvement in Reproductive Health. New York.
- AVSC International. 1997. Men As Partners Initiative: Summary Report of Literature Review and Case Studies. New York.
- Khan M.E, Patel. B.C. 1997. Male Involvement in Family Planning. New Delhi: The Population Council
- Ladig Larry 1996. The Society for Psychological Study of men and masculinity. ____ The American Psychological Association
- Mundigo Axel. 1995. Men's Roles, Sexuality and Reproductive Health, Chicago, The John D And Catherine T MacArthur Foundation
- Sato D, Gordon D.F. 1995. Men's Health and Illness. Thousand Oaks. Sage Publications
- The Alan Guttmacher Institute. 1996. Reradings on Men. New York
- UNFPA 1998. A new Role for Men: Partners for Women's Empowerment. New York
- Vissaria Leela. 1998. Men as Supportive Partners in Reproductive and Sexual Health. New Delhi. The Population Council
- Wegner M.N, et al _____. Men as Partners in Reproductive Health : From Issues to Action. International Family Planning Perspectives

Journals - These are two journals dealing with the emerging discipline of Men's Studies

1. The Journal of Men's studies; c/o James Doyle, P.O. Box 32, Harriman, TW 377 48-0032, USA.
2. Masculinities - c/o Michael Kinmel; Dept. Of Sociology; S.U.N.Y. at Story Brook, Story Brook, NY-11794-4396, USA.

Resource Organisations

The whole issue of Men's involvement and participation is relatively new and unexplored. Some of the organisations which could help by providing information and materials on men's health and involvement are as follows:

1. AVSC International

The organisation works worldwide to improve the lives of individuals by making reproductive health (RH) services safe, available and sustainable. AVSC provides technical assistance, training and information, with a focus on practical solutions that improve services where resources are scarce.

US address: 79 Madison Avenue, New York, NY 10016 USA

Telephone: 212-561-8000; Fax: 212-779-9439

e-mail: info@avsc.org; World Wide Web: <http://www.avsc.org>

India address: IFPS Liaison Office, 4/2 Shantiniketan, New Delhi - 110 021, Delhi

Contact person: Nirmala Selvam, Programme Associate

2. PATH

PATH is primarily involved in promoting appropriate technology for health but it has also been involved in preparing and providing resources for involving men.

4, Nickerson Street,
Seattle, WA 98109-1699

USA

3. Population Council

The South East Asia Regional Office at New Delhi is actively involved in creating greater understanding on the subject of Men's involvement.

South and East Asia Regional Office

Zone 5A, Ground Floor, India Habitat Centre

Lodi Road, New Delhi - 110 003

Tel: 464 2901, 2902, 4008, 4009; Fax: 464 2903

E-mail: pcindia@popcouncil.org

Contact person: Dr. Saroj Pachauri, Regional Director

5. Parivar Sewa Sansthan (PSS)

PSS is involved in trying out new strategies in involving men in reproductive health programmes.

Parivar Seva Sanstha, C-374, Defence Colony, New Delhi-110 024, Tel: 4617712/

4619024, Fax: 4620785, E-mail: pssindia@viasdl01.vsnl.net.in

6. CHETNA

CHETNA has been evolving new training modules and strategies for incorporating men in reproductive health programmes.

Centre for Health Education, Training and Nutrition Awareness (CHETNA)

Lilavatiben Lalbhai's Bungalow

Civil Camp Road, Shahibaug

Ahmedabad 380 004

Tel: 079-2868856/ 2866695; Fax: 079-2866513

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**Understanding
Reproductive Health**

A Resource Pack

Booklet – Ten

HIV, AIDS & STD:
Coming to terms with reality

SAHAYOG

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INTRODUCTION

The Acquired Immuno-Deficiency Syndrome, or the AIDS, is today one of the most insidious threats facing humankind. From Africa to the USA, from the Cameroons to India, the virus has spared no nation. Today, vigorous and determined prevention efforts have begun bringing down the infection rate in several countries like the USA and Thailand. However, in developing countries like India, where the epidemic is just beginning to take root, are badly off. Indeed, thanks to its enormous population, India has the dubious distinction of having the largest HIV positive population in the world. AIDS is a special disease in many ways. It is incurable; there is no vaccine in sight. It is infectious. And the spread of the virus is closely linked with human sexual promiscuity, risk-taking behaviour, drug use, and other desperate behaviour. As a result, HIV/AIDS has never been an easy subject to broach within society. And the epidemic's spread has always been accompanied by a surge of discrimination, stigmatisation and ostracisation. Today, HIV/AIDS is acknowledged to be a social epidemic first, and then a medical one. Its prevention and control require changes in our social value system, relationship structures, attitudes and behaviour. The disease has several ramifications, including social, medical, clinical, legal, human rights, and economic ones.

Sexually Transmitted diseases (STDs) or Sexually Transmitted Infections as they are often called are one of the most widely occurring diseases in the world. The emergence of AIDS as one of the main scourges of mankind has focussed the attention on STDs because they share an important route of spread, and the presence of STDs increases the vulnerability to AIDS manifold.

In this fact sheet we shall look at what is known today about AIDS, HIV and STDs within the framework of India's social situation, and finally at some aspects of AIDS programming for those wishing to work in this area.

Section One

AIDS and STDs: Some Basic Information

History

In June 1981, doctors in New York were baffled by what they were sure was the outbreak of a dreadful new disease, when 41 patients, all in their twenties, all men, all gay, reported a rare skin cancer called Kaposi Sarcoma, found only in the Mediterranean region, amongst people who were 80 years or older. Closer examination revealed that the immune system's of these young men were also severely impaired.

The disease was promptly named the Gay Cancer, as similar reports started pouring in from all over America and then the Western Europe. The right wing promptly called it the curse of God on people who commit the sin of homosexuality. But within a year it was clear that heterosexuals were getting infected too. America was at the peak of its revolution of sexual permissiveness and this information came as a rude shock. In the year 1982, the disease was rechristened as the Acquired Immune Deficiency Syndrome or AIDS. During the following year, 1983, the virus causing AIDS was first discovered and named the HIV or the Human Immunodeficiency Virus. Since then three different strains of HIV virus have been isolated.

The Origin of the Human Immuno-deficiency Virus (HIV)

There have been several theories on the origin of the HIV virus. From 'green monkeys in Africa' to 'germ warfare developed by the US army' to 'a secret virus developed by the US government to finish the American gay population'. Findings presented at the 6th Conference on Retroviruses and Opportunistic Infections held in Chicago from January 31 to February 4, 1999, provide the strongest evidence to date that HIV-1 originated in non-human primates, probably chimpanzees. Researchers from the University of Alabama at Birmingham presented evidence identifying a new isolate of a retrovirus affecting a chimpanzee subspecies (*Pan troglodytes troglodytes*) and showed that this and other chimpanzees isolates are related to the different groups of HIV-1 affecting humans. According to Dr. Hahn and colleagues, the establishment of HIV-1 in humans is likely to have resulted from cross-species transmission.

What is AIDS ?

AIDS stands for Acquired Immuno-Deficiency Syndrome. An HIV-infected person receives a diagnosis of AIDS after developing one of the AIDS indicator illnesses defined by the Center for Disease Control, USA.. An HIV-positive person who has not had any serious illnesses also can receive an AIDS diagnosis on the basis of certain blood tests (CD4+ counts). A positive HIV test result does not mean that a person has AIDS. A diagnosis of AIDS is made by a physician using certain clinical criteria (e.g., AIDS indicator illnesses). Infection with HIV can weaken the immune system to the point that it has difficulty fighting off certain infections. These types of infections are known as

"opportunistic" infections because they take the opportunity a weakened immune system gives to cause illness. Many of the infections that cause problems or may be life-threatening for people with AIDS are usually controlled by a healthy immune system. The immune system of a person with AIDS is weakened to the point that medical intervention may be necessary to prevent or treat serious illness. Today there are medical treatments that can slow down the rate at which HIV weakens the immune system. There are other treatments that can prevent or cure some of the illnesses associated with AIDS. As with other diseases, early detection offers more options for treatment and preventative care.

The World Health Organisation has produced a clinical case definition that is used in India for diagnosing a person as having AIDS. According to this if the person has

- Two major signs, including a loss of ten percent of body weight within a short period, chronic diarrhoea persisting for more than a month and chronic fever for more than one month,
- At least one minor sign, including persistent cough for more than a month, dermatitis, shingles, oral thrush, chronic herpes simplex and generalized enlargement of the lymph nodes,
- and no other known causes of immunosuppression, s/he may be suspected to have AIDS.

What is HIV ?

HIV as has been earlier mentioned is the virus which causes AIDS. When a person is infected with HIV but has not yet developed AIDS the person is known as HIV positive. Thus a person with HIV infection need not necessarily be suffering from AIDS, which leads to the use of the composite term HIV/AIDS.

Two types of HIV have been identified to date: HIV-1 and HIV-2. HIV-1 is the predominant HIV type in the United States and throughout the world. HIV-2 is primarily found in West Africa. As mentioned earlier the origin of HIV-1 is from primates, most possibly from chimpanzees. The origin of HIV-2 has been identified as being another monkey species, the sooty mangabey (*Cercocebus atys*); Dr. Hahn also played a key role in that research. This new knowledge about the virus and its transmission can lead to a better understanding of the evolution of HIV-1, provide insight into species-to-species transmission of viruses, and increase our understanding of infectious disease emergence. Deeper understanding of strain evolution could in the longer term be of relevance to the development of diagnostic assays and vaccines.

HIV has a relatively low infectivity, as compared to Hepatitis B virus. It thus requires a much larger number of viruses to enter the body to cause disease (check). Further more the ability of the HIV to survive in the external environment is also low, eg. simple drying kills the virus, a temperature of 56 degrees Centigrade is fatal, chlorination, bleaching and even plain detergent also kills the virus. This knowledge is very useful in prevention of the disease.

The HIV Continuum

As mentioned earlier the infection with HIV does not immediately lead to the development of AIDS. The period from the HIV infection to the development of full blown AIDS is known as the HIV Continuum.

Early Symptoms

Many people do not develop any symptoms when they first become infected with HIV. Some people, however, have a flu-like illness within a month or two after exposure to the virus. They may have fever, headache, malaise and enlarged lymph nodes (organs of the immune system easily felt in the neck and groin). These symptoms usually disappear within a week to a month and are often mistaken for those of another viral infection. People are very infectious during this period, and HIV is present in large quantities in genital secretions.

More persistent or severe symptoms may not surface for a decade or more after HIV first enters the body in adults, or within two years in children born with HIV infection. This period of "asymptomatic" infection is highly variable. Some people may begin to have symptoms in as soon as a few months, whereas others may be symptom-free for more than 10 years. During the asymptomatic period, however, HIV is actively multiplying, infecting and killing cells of the immune system. HIV's effect is seen most obviously in a decline in the blood levels of CD4+ T cells (also called T4 cells) — the immune system's key infection fighters. The virus initially disables or destroys these cells without causing symptoms.

As the immune system deteriorates, a variety of complications begins to surface. One of the first such symptoms experienced by many people infected with HIV is large lymph nodes or "swollen glands" that may be enlarged for more than three months. Other symptoms often experienced months to years before the onset of AIDS include a lack of energy, weight loss, frequent fevers and sweats, persistent or frequent yeast infections (oral or vaginal), persistent skin rashes or flaky skin, pelvic inflammatory disease that does not respond to treatment, or short-term memory loss. Some people develop frequent and severe herpes infections that cause mouth, genital or anal sores, or a painful nerve disease known as shingles. Children may have delayed development or failure to thrive.

AIDS

The term AIDS applies to the most advanced stages of HIV infection. In 1993, the Centre for Disease Control, Atlanta, USA, revised its definition of AIDS to include all HIV-infected people who have fewer than 200 CD4+ T cells. (Healthy adults usually have CD4+ T-cell counts of 1,000 or more.) In addition, the definition includes 26 clinical conditions that affect people with advanced HIV disease. Most AIDS-defining conditions are opportunistic infections, which rarely cause harm in healthy individuals. In people with AIDS, however, these infections are often severe and sometimes fatal because the immune system is so ravaged by HIV that the body cannot fight off certain bacteria, viruses and other microbes.

Opportunistic infections common in people with AIDS cause such symptoms as coughing, shortness of breath, seizures, mental symptoms such as confusion and forgetfulness, severe and persistent diarrhoea, fever, vision loss, severe headaches, weight loss, extreme fatigue, nausea, vomiting, lack of coordination, coma, abdominal cramps, or difficult or painful swallowing.

Although children with AIDS are susceptible to the same opportunistic infections as adults with the disease, they also experience severe forms of the bacterial infections to which children are especially prone, such as conjunctivitis (pink eye), ear infections and tonsillitis.

People with AIDS are particularly prone to developing various cancers, especially those caused by viruses such as Kaposi's sarcoma and cervical cancer, or cancers of the immune system known as lymphomas. These cancers are usually more aggressive and difficult to treat in people with AIDS.

Many people are so debilitated by the symptoms of AIDS that they are unable to hold steady employment or do household chores. Other people with AIDS may experience phases of intense life-threatening illness followed by phases of normal functioning.

A small number of people (less than 50) initially infected with HIV 10 or more years ago have not developed symptoms of AIDS. Scientists are trying to determine what factors may account for their lack of progression to AIDS, such as particular characteristics of their immune systems, or whether they were infected with a less aggressive strain of the virus or if their genetic make-up may protect them from the effects of HIV. Scientists hope that understanding the body's natural method of control may lead to ideas for protective HIV vaccines and use of vaccines to prevent disease progression.

Diagnosis of HIV and AIDS

Because early HIV infection often causes no symptoms, it is primarily detected by testing a person's blood for the presence of antibodies (disease-fighting proteins) to HIV. HIV antibodies generally do not reach detectable levels until one to three months following infection and may take as long as six months to be generated in quantities large enough to show up in standard blood tests. This initial period when the person is infected but does not have enough antibodies to be detected as HIV positive is known as the "window period". HIV testing may also be performed on saliva and urine samples, in addition to blood samples.

Box- Testing for HIV

ELISA Test -This test actually looks for antibodies produced by your body to fight HIV. Most people will develop detectable antibodies within 3 months after infection, the average being 25 days. In rare cases, it can take up to 6 months. For this reason, currently testing is recommended six months after the last possible exposure (unprotected vaginal, anal, or oral sex or sharing needles). It would be extremely rare to take longer than six months to develop detectable antibodies. It is important, during the six months between

exposure and the test, to protect yourself and others from further possible exposures to HIV.

Western blot -This more specific (and more expensive) second test can differentiate between HIV antibodies and other antibodies that cause the ELISA Test to display a false positive result. Although false positive ELISA results are uncommon, they can occur when the test mistakes other antibodies that the body has manufactured to fight other foreign substances for those produced to fight HIV. A repeatedly reactive result from the ELISA, confirmed by the Western blot test, is taken to indicate the presence of HIV antibodies; the individual tested is considered to be infected.

In addition to the ELISA test, and Western Blot other tests now available include:

- * Radioimmunoprecipitation assay (RIPA): A confirmatory blood test that may be used when antibody levels are very low or difficult to detect or when Western blot test results are uncertain. An expensive test, the RIPA requires time and expertise to perform.

- * Rapid latex agglutination assay: A simplified, inexpensive blood test that may prove useful in medically disadvantaged areas where there is a high prevalence of HIV infection.

- * Dot-blot immunobinding assay: A rapid-screening blood test that is cost-effective and that may become an alternative to conventional EIA and Western blot testing.

- * p24 antigen capture assay: Also known as the HIV-1 antigen capture assay. This blood test was added as an interim measure by the Food and Drug Administration (FDA) in 1996 to HIV-antibody testing to protect the blood supply further until other tests become available to detect early HIV infection before antibodies are fully developed. Because some activity of p24 antigen is unpredictable, this test is not useful for helping people find out if they have HIV.

- * Polymerase chain reaction (PCR): A specialized blood test that looks for HIV genetic information. Although expensive and labor-intensive, the test can detect the virus even in someone only recently infected. To further protect the blood supply, the FDA has indicated that the development and implementation of tests for HIV genetic material such as PCR is warranted.

(End Box)

People exposed to HIV should be tested for HIV infection as soon as they are likely to develop antibodies to the virus. Such early testing will enable them to receive appropriate treatment at a time when they are most able to combat HIV and prevent the emergence of certain opportunistic infections (see **Treatment** below). Early testing also alerts HIV-infected people to avoid high-risk behaviour that could spread HIV to others. HIV testing is done in most doctors' offices or health clinics and should be accompanied by counseling. Individuals can be tested anonymously at many sites if they have particular concerns about confidentiality. In addition, blood samples for anonymous HIV testing may now be collected at home. Home-based test kits are available in developed countries which can be obtained by telephone order or over the counter at pharmacies.

Two different types of antibody tests, ELISA and Western Blot, are used to diagnose HIV infection. If a person is highly likely to be infected with HIV and yet both tests are negative, a doctor may test for the presence of HIV itself in the blood. The person also

may be told to repeat antibody testing at a later date, when antibodies to HIV are more likely to have developed.

Babies born to mothers infected with HIV may or may not be infected with the virus, but all carry their mothers' antibodies to HIV for several months. If these babies lack symptoms, a definitive diagnosis of HIV infection using standard antibody tests cannot be made until after 15 months of age. By then, babies are unlikely to still carry their mothers' antibodies and will have produced their own, if they are infected. New technologies to detect HIV itself are being used to more accurately determine HIV infection in infants between ages 3 months and 15 months. A number of blood tests are being evaluated to determine if they can diagnose HIV infection in babies younger than 3 months.

HIV transmission

HIV transmission can occur when blood, semen (including pre-seminal fluid), vaginal fluid, or breast milk from an infected person enters the body of an uninfected person. HIV can enter the body through a vein (e.g., injection drug use), the anus or rectum, the vagina, the penis, the mouth, other mucous membranes (e.g., eyes or inside of the nose), or cuts and sores. Intact, healthy skin is an excellent barrier against HIV and other viruses and bacteria. These are the most common ways that HIV is transmitted from one person to another:

- by having sexual intercourse (anal, vaginal, or oral sex) with an HIV-infected person
- by sharing needles or injection equipment with an injection drug user who is infected with HIV
- from HIV-infected women to babies before or during birth, or through breast-feeding after birth
- HIV also can be transmitted efficiently through transfusions of infected blood.

Box

HIV cannot be transmitted through

- Social contacts like touching, hugging, etc.
- Light kissing
- sharing foods, clothes etc.
- Mosquitoes or other insect bites
- using public toilet, telephone, swimming pool, etc. (End Box)

An estimated 95% of recipients become infected from transfusion of a single unit of infected whole blood. The per-contact probability of transmission from an HIV-infected source is much lower for injecting-drug-use and sexual exposures. The risk for HIV transmission per episode of intravenous needle or syringe exposure is estimated at 0.67%. Prospective surveillance studies indicate that the risk per episode of percutaneous exposure (e.g., a needle-prick) to HIV-infected blood is estimated at 0.4%. The level of risk associated with the exposure of non-intact skin or mucous membranes to HIV-infected blood is far less than that associated with needle-prick exposures.

Some health-care workers have become infected after being pricked with needles containing HIV-infected blood or, less frequently, after infected blood contact with the worker's open cut or through splashes into the worker's eyes or inside their nose. There has been only one instance of patients being infected by an HIV-infected health care worker. This involved HIV transmission from an infected dentist to six patients. The risk for HIV transmission per episode of receptive penile-anal sexual exposure is estimated at 0.1%-3%; the risk per episode of receptive vaginal exposure is estimated at 0.1%-0.2%. No published estimates of the risk for transmission from receptive oral exposure exist, but instances of transmission have been reported.

BOX

Efficiency of HIV transmission by various routes in South East Asia Region

Route of Transmission	Efficiency	% of Total
Sexual	0.1 - 1.0%	80 - 90%
Blood Transfusion	>90%	3 - 5%
Injecting Drug Use	5 - 10%	5 - 10%
Equipment/ Needles	< 0.5%	<0.1%
Perinatal	15 - 45%	<0.1%

Source - WHO

Prevention of HIV

There are no effective cures for HIV/AIDS and thus prevention remains the most important tool in the fight against this disease. Some of the preventive strategies are outlined below.

Through sexual route:

- Celibacy
- Having sex only within marriage, if the spouse is HIV negative
- Having sex with only one faithful sexual partner who is HIV negative.
- If unable to do the above use safer-sex including the proper and regular use of condoms.

Through Blood:

- Avoiding blood transfusion except in cases of emergencies. Check with the doctor whether the requirement is for whole blood or a blood component, such as platelets or plasma.
- If the hospital permits and you have sufficient advance notice of the need for blood transfusion, then the safest route for you is auto-transfusion, in which you donate your own blood for later transfusion back into yourself. The hospital must label your blood with your name, and you should verify that the same blood is being supplied to you.
- If you have sufficient time, arrange for donors from among friends and relatives who to your knowledge are not likely to have practiced high-risk behaviour. In addition, make sure their donated blood is tested HIV free and is labelled clearly for later transfusion back into you.

- Sterilizing the needles, syringes, and other surgical instruments before using on another person. Use only disposable needles and syringes..
- Taking oral drugs instead of IV drugs. Not sharing needles/syringes when taking IV drugs. If one has to share these, both needle and syringe should be properly sterilized.
- Sterilizing tattooing equipment and those used for piercing body parts after each use.

Prevention through awareness -

- IEC Campaigns in the mass media for the general public
- Training of Health Care personnel at all levels
- Change attitudes towards safer sex
- Creating a demand in the community for safer medical and related services

Risk behaviour- AIDS recognises no barriers and it can strike people at any age . However some men and women are more vulnerable because of risk behaviours. These risk behaviours include- engaging in sex with multiple partners, inability to negotiate safer sex practices like use of condom, sharing unclean and used injecting equipment like syringes and needles, transfusion of blood or blood products that have not been screened for HIV antibodies

STD's

Sexually Transmitted Diseases (or infections) are those diseases which are transmitted through sexual contact with another person. These are among the commonest diseases in the world. According to estimates of the WHO over 300 million new cases of STDs occur every year in the world. This makes them the fourth most common infectious disease after diarrhoea, malaria and acute respiratory tract infection. The commonest microorganisms causing these are chlamydia, trichomona, syphilis and gonorrhoea.. Most STD's are now treatable if treatment is sought in time. AIDS is an exception, which has no cure.

STD's symptoms in men

The most common STD symptoms in men include:

- Pain when passing urine
- yellow discharge from the penis.
- Sores and blisters in the genital area, including the anus. These sores can be painful or painless.
- Itching in the genital area
- Infection of the anus sometimes causes discharge and irritation
- Enlargement of groin lymph nodes

STD symptoms in women

STD's may not always show symptoms in women. If present they include:

- Burning feeling when passing urine
- Unusual vaginal discharge
- Infection of anus sometimes causes discharge and irritation.
- Pain in the lower abdomen

- Sores, blisters etc. around the genital areas including the anus. These sores may or may not be painful.
- Enlargement of groin lymph nodes

If STD's are not treated in time, they can lead to several incurable disabilities, including, sterility, blindness, impotence, etc. and can even be fatal. Some of the common STD's are:

- * Gonorrhea
- * Syphilis
- * Herpes
- * Genital Warts
- * Pubic lice
- * Scabies
- * AIDS
- * Hepatitis B

Having an STD increases the chances of a person for getting infected with HIV by upto 10 times.

Prevention of STD's :

The best way to prevent STD's is of course to have safer-sex including proper and regular use of condoms. In the case of STDs there is also a concept of secondary prevention in which the effort is to restrict spread from one infected person and the measures that can be taken include- seeking early medicare, early diagnosis and treatment and partner notification.

Safer Sex

Since no vaccine for HIV is available, the only way to prevent infection by the virus is to avoid behaviours that put a person at risk of infection, such as sharing needles and having unprotected sex. Because many people infected with HIV have no symptoms, there is no way of knowing with certainty whether a sexual partner is infected unless he or she has been repeatedly tested for the virus or has not engaged in any risky behaviour. CDC recommends that people either abstain from sex or protect themselves by using male latex condoms whenever having oral, anal or vaginal sex. Only male condoms made of latex should be used, and water-based lubricants should be used with latex condoms. Although some laboratory evidence shows that spermicides can kill HIV organisms, in clinical trials, researchers have not found that these products can prevent HIV. The risk of HIV transmission from a pregnant woman to her foetus is significantly reduced if she takes AZT during pregnancy, labour and delivery, and her baby takes it for the first six weeks of life.

Box-

Given below is a list of some commonly practiced sexual activities and the risk of HIV transmission they involves.

NO RISK	Masturbation, seeing pornographic movies, fantasizing, erotic massage, etc., using sex toys which are clean and not shared.
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VERY LOW RISK	Mutual masturbation, petting, kissing, etc., using sex toys that are shared but cleaned.
LOW RISK	Deep Kissing, Oral intercourse with condoms, Oral intercourse without condoms but not ejaculating in mouth, Vaginal/anal intercourse with condoms.
VERY HIGH RISK	Vaginal/Anal intercourse without condoms, Oral intercourse without condoms and ejaculating in the mouth, Sharing Sex-toys that are not properly cleaned.

Treatment of HIV related infections

When AIDS first surfaced in the United States, no drugs were available to combat the underlying immune deficiency and few treatments existed for the opportunistic diseases that resulted. Over the past 10 years, however, therapies have been developed to fight both HIV infection and its associated infections and cancers. The Food and Drug Administration of the USA has approved a number of drugs for the treatment of HIV infection. The first group of drugs used to treat HIV infection, called nucleoside analog reverse transcriptase inhibitors (NRTIs), interrupt an early stage of virus replication. Included in this class of drugs are zidovudine (also known as AZT), zalcitabine (ddC), didanosine (ddI), stavudine (D4T), lamivudine (3TC) and abacavir succinate. These drugs may slow the spread of HIV in the body and delay the onset of opportunistic infections. Importantly, they do not prevent transmission of HIV to other individuals. Non-nucleoside reverse transcriptase inhibitors (NNRTIs) such as delavirdine, nevirapine and efavirenz are also available for use in combination with other antiretroviral drugs.

A third class of anti-HIV drugs, called protease inhibitors, interrupts virus replication at a later step in its life cycle. They include ritonavir, saquinavir, indinavir and nelfinavir. Because HIV can become resistant to each class of drugs, combination treatment using both is necessary to effectively suppress the virus. Currently available antiretroviral drugs do not cure people of HIV infection or AIDS, however, and they all have side effects that can be severe. AZT may cause a depletion of red or white blood cells, especially when taken in the later stages of the disease. If the loss of blood cells is severe, treatment with AZT must be stopped. DdI can cause an inflammation of the pancreas and painful nerve damage.

The most common side effects associated with protease inhibitors include nausea, diarrhoea and other gastrointestinal symptoms. In addition, protease inhibitors can interact with other drugs resulting in serious side effects. Investigators also recently have reported cases of abnormal redistribution of body fat among some individuals receiving protease inhibitors. A number of drugs are available to help treat opportunistic infections to which people with HIV are especially prone. These drugs include foscarnet and ganciclovir, used to treat cytomegalovirus eye infections, fluconazole to treat yeast and other fungal infections, and TMP/SMX or pentamidine to treat *Pneumocystis carinii* pneumonia (PCP).

Alternative medicine & healing and HIV

Many alternative forms of medicines have offered relief (not cure) to people living with HIV virus. These medicines work in two ways. On one hand they help replenish the depleted immune-system and also reduce further spread of HIV, and on the other hand they provide a psychological benefit. These alternative forms of medicine often make use of ancient knowledge and practices. These include Ayurveda, Acupuncture, Yoga, Reiki, etc. These alternative medicines or healing should not be used on their own, but only as complementary to more established forms of treatment.

Quackery and HIV

Even though there are no cures for HIV virus, many quacks in India and elsewhere have been claiming to cure people with AIDS or to have developed special cures. They exploit the helplessness felt by many people living with AIDS as far as a cure is concerned. There is no truth whatsoever in such claims. At present there is no law in India to deal with such quacks.

Section Two

AIDS and Society in India

AIDS in India

The first case was reported in 1986, more than 5 years after it was first discovered in the US. However, we have failed to make use of the early warning. Thus, despite many millions of dollars being spent in "raising awareness" about HIV/AIDS during the last decade, India's first reaction, as every other nation that has come face to face with the prospect of AIDS for the first time, was also a 'no' and a shrug. Fortunately, however, in its earliest days the programme was guided by the global experience of those who had already seen how bad it was going to get. The AIDS control initiatives that India launched between 1992 and 1997, whose outcomes have now been evaluated by the National AIDS Control Organisation (NACO) and other agencies, have made considerable inroads against HIV/AIDS.

The efforts were largely based on the assumption that individuals will make a rational choice and adopt the steps prescribed as protection, once they are convinced about their susceptibility to HIV and the details of the threat they face from AIDS. Accordingly, Information-Education-Communication (IEC), and its concomitant 'awareness-raising' have been the cornerstones of public communication. We have passed through a phase of a sort of carpet-bombing of the public consciousness with the 'facts about HIV and AIDS'. IEC has helped to move the hitherto taboo topics of HIV infection and AIDS into the public domain. HIV/AIDS education is now a part of primary school curriculums. In important and influential communities, one no longer hesitates before talking about AIDS, or admitting ignorance about it, or even openly asking a question relating to personal sexuality. *NACO assesses the levels of awareness of HIV/AIDS in urban India to be around 70% now, though in rural areas it is not over 30%.*

Targeted interventions focus on the hotbeds: The more focussed technologies of safety and prevention moved in parallel, covering the gamut of issues from blood safety to STD control and condom programming. The virus's hatcheries had to be identified and aimed at: commercial sex districts topped the list, and within them chiefly women sex workers; communities of injecting drug users; professional blood donors; blood banks themselves; and more recently, truckers. Hidden within this paradigm of 'targeted interventions' was also a philosophy of containment, akin to malaria control by fumigation to destroy mosquito larvae. The assumption was that you can prevent the virus' spread by identifying the communities rendered most vulnerable either through their behaviour or their oppressed lifestyles. The appropriate steps include measures to raise their awareness while increasing their access to preventive technologies.

Donated blood becomes safe: In these five years, donated blood has also started becoming safer in India, with the phasing out of unlicensed blood banks and professional blood donors, as well as a vigorous drive to increase voluntary blood donations. In the years ahead, regional blood banks with state-of-the-art facilities for collecting, processing

and storing whole as well as component blood will bring the prospect of safer blood closer to every Indian.

The virus is still winning: The previous period of the epidemic in India, when relatively fewer states were in the active focus of HIV and the emphasis was on preventive strategies, has yielded to a more alarming phase. At the end of five years of programming, current figures are showing that HIV has been steadily gaining, especially in the states that have seen maximum preventive activities, Maharashtra and Tamil Nadu. Studies conducted in 1998 in 180 ante-natal clinics have shown that in five Indian states, prevalence has crossed 1% in the general population. These states include Maharashtra (2.4%) and Tamil Nadu (1.1%), besides Karnataka (2.3%), Andhra Pradesh (1.6%), Manipur (1.2%). Based on NACO's surveillance figures of 77,881 seropositive Indians as of June 1998, WHO estimates a current national total of over 41,00,000 adults and children living with HIV/AIDS (or over 1% of the population). WHO also estimates a total of 4,30,000 AIDS cases since the beginning of the epidemic in India, of whom 3,50,000 have already died, more than a third of *them* in 1997 alone. The estimated number of children who have lost their mother or both parents to AIDS while they were under age 15, since the beginning of the epidemic, is 1,20,000. (*Caution: Such estimates must be considered with care; on the one hand, they serve to remind us that the actual problem's dimensions may be larger than the so-called official figures indicate; on the other hand, WHO itself warns us that they are extrapolations from low-quality and often incomplete data.*)

Highest prevalence in areas of maximum focus: Hidden within the numbers, such as they are, are also trends that reveal *increases particularly in areas that have been receiving much attention as 'centres of spread'*. These are the regions where the hot light of international focus has shone brightly, such as Manipur, and Mumbai's sex district, Kamathipura. Among sex workers in Mumbai, HIV prevalence rates have increased from 1% in 1986 to 15% in 1989 to 50% in 1994. The manager of Kamathipura's oldest targeted intervention project estimates that today's figure may be over 60%. Though data from Kamathipura is still controversial and sparse, the bulk of these infections are likely to have occurred concurrent with prevention efforts. "There is a very high rate of sex worker turnaround within brothels," says the manager of one of Kamathipura's earliest interventions. "If a sex worker is found HIV positive, the community will generally expel her as soon her health and earning ability begin to decline. She will be sent home. Prevalence figures are more likely to indicate infection among newcomers." Among injecting drug users, HIV prevalence in Manipur seems to have stabilised at around 65%, but serosurveys among IDUs in Calcutta and Chennai show that the number is still increasing. HIV prevalence among STD patients in Chennai and Mumbai rose from 17% in 1996 to 33% in 1997; it is presumably even higher now.

Women and AIDS

The incidence of HIV and AIDS among women is rising- In 1990, the World Health Organization estimated that there were between 8 and 10 million people worldwide infected with HIV. More than 3 million of these people are women. Even more alarming is the rate at which infection among women has been increasing. The number of infected women rose sharply during the second half of the 1980's and, in some areas of Africa,

Latin America and the Caribbean, there was more than a fourfold increase over a period of between two and four years. It is estimated that during the next decade the prevalence of HIV infection among women will equal and, in some cases, overtake that of men. The World Health Organization estimates that during the 1990's, the number of women and children dying of AIDS will rise to 3 million. In most central African cities and in some major cities in America and Western Europe, AIDS is already the leading cause of death for women between the ages of 20 and 40. In sub-Saharan Africa over the next few years, infant mortality is expected to increase by up to 30% as a result of perinatal transmission of HIV.

It is estimated that approximately 80% of the total number of women and children currently infected with HIV are in sub-Saharan Africa. In this region, one in every twenty adult women is thought to be infected, and women represent more than 50% of the total number of AIDS cases. The majority of infected women are of child bearing age, opening the way for perinatal HIV transmission to these women's children on a large scale. UNDP has estimated that over 85% of the cases of paediatric infection in Africa have resulted from perinatal transmission. For the Caribbean the estimate is 97.5%. Even where the children do not themselves have HIV infection, the number of children orphaned by AIDS is increasing rapidly. World Health Organization has estimated that as many as 10 million children in sub-Saharan Africa will be orphaned by the epidemic by the end of the 1990's.

Why women are at increased risk and are more vulnerable- The primary HIV risk activity for women globally is sexual activity. Over 90% of women currently infected with HIV have been infected as a result of transmission through vaginal intercourse. Efficacy of transmission is increased where women have poor general health and suffer from genital lesions, inflammation, secretions and scarification. Women are also at increased risk of being infected with HIV infection through contaminated blood and injections because of the high incidence of blood transfusions and injections associated with pregnancy, childbirth and post-pregnancy haemorrhage or treatment for anaemia caused by repeated pregnancies.

The World Health Organization has admitted that its estimates of the levels of infection among women and children should be viewed as very conservative. It is likely that under-reporting of HIV infection and AIDS in parts of Africa, the Caribbean and Asia, where women make up a large proportion of the infected population, has helped to conceal the true levels of infection. However, even the estimates currently available leave no doubt as to the magnitude of the impact of the HIV epidemic on women.

Physiologically speaking, women in general are more vulnerable than men because women receive semen from men, and it stays in the vaginal canal for sometime, giving the virus time to take root. Women also have a more extensive surface area of mucus membrane in the vagina and on the cervix. Young women are at an especially high risk of contracting HIV. Women in the age group 15-25 year age group have the highest rate of HIV. The corresponding age group for men is 25-30 years. In young women the vagina is not well lined with protective cells, the cervix may be more easily eroded and tearing of

the hymen during first intercourse can cause bleeding. Similarly, women going through menopause will often have a thinning of the vaginal mucus which make them more susceptible.

The link between powerlessness and the risk of exposure to HIV provides the key to understanding the source of women's vulnerability to HIV infection. It is the reason why HIV infection is increasingly a condition of all women, regardless of race, colour or economic status. In more developed countries, the full impact of these social and cultural dynamics was not apparent in the early years of the epidemic when the majority of reported cases was among homosexual men. With dramatic increases in infection levels in women in both the developed and the developing world, however, there has been a shift in the global demographics of HIV infection. This shift has forced a reassessment of the role of socioeconomic factors in the spread of HIV in order to address the ways in which women are being affected by the epidemic.

The need to redefine AIDS - The male orientation of the understanding of the epidemic to date is evident also in the way HIV-related illnesses and AIDS have been defined. The case definition of AIDS issued by the United States Centres for Disease Control and used worldwide focuses on the marker diseases that are characteristic of HIV-related illness in men and omits conditions that often signify the onset of HIV-related conditions and AIDS in women, including pelvic inflammatory disease, cervical cancer, vaginal candidiasis and conjunctivitis. This has had serious consequences for women, leaving many women undiagnosed or wrongly diagnosed, delaying diagnosis and treatment and denying women access to disability and other benefits and services because they have not been diagnosed with AIDS.

Women, AIDS and gender - The patterns of social and economic dependency that render women vulnerable to HIV infection are manifested in many different ways. First and foremost, they lead to women being deprived of the power to determine the basis upon which their sexual relationships with men take place. For many women, sexual intercourse is not a question of choice but rather a question of survival. Cultural attitudes and norms leave no place for unmarried or childless women. A woman's fertility and her relationship to her husband will often be the source of her social identity. Moreover, for many women, marriage provides forms of economic and social support that would not be available to them if they were to remain single. Similar social constructs also dictate that a married woman has little or no power to negotiate the basis upon which her sexual relationship with her husband will take place. Once married, women are usually expected to remain faithful to their husbands but are unable to compel fidelity in return. In many parts of the world, multiple sexual relationships on the part of men are actively condoned or at least regarded as an acceptable practice. The tendency for men to have sexual relationships outside their marriage is reinforced by male migration and mobility common in many developing countries where men leave the village to obtain work elsewhere.

Women have little alternative but to accept the risk that sexual intercourse with their husband entails. They usually have little or no means of support for themselves and their

children other than by remaining within the marriage. Even if condoms were available to them at an affordable price, most women would not be able to ensure that their husbands used them. Although it is almost invariably the husband who is the vector of HIV infection for wives, a married woman who is found to be infected with HIV will often be expelled from the family unit by the husband. The husband will then seek a new wife, often a younger woman who is believed to be uninfected and therefore safe and who, in turn, will be exposed to HIV. In some parts of Africa, there have been reports of increased rape of young girls, because they are believed to be free of HIV infection.

AIDS and Commercial Sex Workers- Prostitution is often the only means of support for deserted, separated, divorced or unmarried older women, highlighting once again the close link between economic need and exposure to HIV infection. The term "prostitution" is used in this paper to refer to a wide variety of ways in which women exchange sexual intercourse for cash or other forms of economic support, food, shelter or care. There has been a serious distortion of the understanding of the way this epidemic has affected women because of the singling out of sex workers by epidemiologists, researchers and national HIV/AIDS programmes as a target or high risk group. The overwhelming majority of women are not sex workers and the largest group of women at high risk of infection are wives. Recent data from Mexico indicate that only 0.8 per cent of all reported AIDS cases have been among sex workers and 9 per cent among housewives. Similar figures can be found in other countries, both developed and developing. In Senegal where the epidemic is still in its infancy (less than 2 percent of the adult population infected), modes of transmission to women in one infectious diseases ward were 20 percent acquired iatrogenically, 30 percent occupationally (sex workers) and 50 per cent had no risk factor other than being a wife. As the epidemic proceeds, the proportion of wives to all infected women increases and that of sex workers and iatrogenically acquired transmission decreases.

The targeting of sex workers encourages blame, stigma and discrimination not only against them but against all women. It allows others, both the men who infect sex workers and the wives of these men, to deny that they are at risk. However, it has brought some benefits to some sex workers. HIV prevention programmes which have provided counselling, support and services for these women and their children and which ensure women access to affordable, quality condoms have assisted women to adopt condom usage in their work. In some cases, sex workers have been empowered through collective action and instituted condoms-only policies in their area of operation.

Human rights, AIDS and the Indian legal system

An agenda for change within the Indian legal system has been the mandate of Mumbai's Lawyers Collective, a small but energetic and highly visible crusading body of lawyers. Currently, within the ambit a project funded by the European Commission, they have set up a HIV/AIDS unit to respond to the legal needs of people living with HIV/AIDS by providing them with free legal services and undertaking advocacy to lobby for an enabling legal environment. Their studies have identified the following issues as needing

advocacy efforts for bringing about legislative change and more effective implementation:

1. The HIV status of a person should not be a ground for divorce or judicial separation or for the denial of custody, maintenance, inheritance, guardianship, adoption etcetera. Amendments in the law are necessary to remove the ground of venereal disease as grounds for divorce.
2. The activity of commercial sex work should be decriminalised, and there should be strict enforcement against trafficking in women/girls.
3. The National Drugs and psychotropic Substances Act should be comprehensively reviewed in the medium term, but in the short term there is an immediate need to decriminalise the use of 'soft drugs', and institute appropriate amendments in the law to promote 'clean needle exchange' programmes.
4. Section 377 of the Indian penal Code, which criminalises homosexual practices, must be repealed.
5. Section 376 of the IPC, relating to rape, should be amended to include offences relating to rape, sexual offences and non-sexual intercourse between two persons, as against offences by a man against a woman, which is what it deals with currently. It must also be amended to include non-consensual sexual intercourse, and sexual assault within marriages as offences.
6. A statute that specifically addresses the needs of HIV positive people and People Living With HIV/AIDS (PLWHA) should be enacted, with the following provisions:
 - ♦ A person shall not be discriminated against on the grounds of his or her seropositivity;
 - ♦ Being seronegative shall not be a condition for appointment to a job, or for continued employment, education, getting medical treatment, avail of travel facilities, benefits of services and so on.
 - ♦ HIV seropositivity shall not be considered a continued illness within the meaning of Section 2 of the Industrial Disputes Act (1947), or be a ground for the termination of employment.
 - ♦ A person shall not be denied any medical treatment or insurance cover on the ground of his or her seropositivity.
 - ♦ All health care workers shall be provided with all the necessary protective gear and equipment, and be insured against all occupational diseases, including HIV.
 - ♦ The practice of testing babies for HIV prior to adoption must be discontinued.
7. The law relating to obscenity must be amended to strengthen the exceptions to Section 299 of the IPC, and thus allow for the dissemination of messages related to safer sex.
8. The law must also provide for the prohibition of claims of remedies for HIV infection and AIDS without the claimant following a procedure to be prescribed by law, with punitive consequences for defaulters.

9. The law and the procedure must be amended to allow for HIV positive litigants to litigate without disclosing their identity and to also prevent their identity from being disclosed or published.

Gaps in the legal framework: While this forms the broad basis for an agenda, two important environmental constraints are beyond its scope:

- ♦ It cannot reach individuals whose rights have been violated unless they come forward with a case.
- ♦ In order for people to step up with cases and complaints, they must be aware of their rights, and also know where to turn for help.

Both of these have long been endemic features of the Indian legal climate, ones which have frustrated activists and lawyers. Not only is it a long hard road of diligent advocacy to bringing about changes in the statutes, but it is an even more arduous process to ensure that those who need the laws know about them, and know where to go for redress.

Because violations of human rights are going to occur even as lobbies mount pressure for re-framing the laws, advocacy strategies must focus squarely at the level of society where the inequities are going to occur, and look for working, immediate solutions that are within the powers of the affected communities.

Living with HIV or AIDS — living positively

In India, there are a number of PLWHA (People Living With HIV and AIDS) groups who have been active since the 1990s. The Indian Network of Positive People (INP+) is the national PLWHA group, several years old, and equipped with government funding to hold national meetings. INP+'s leaders have been sent on study tours of Thailand, and has a workplan that addresses networking, skills building, representation and advocacy. A PLWHA is represented on NACO, but in the field, there is hardly any contact either between NGOs working in HIV, or between NGOs and groups of PLWHA.

Thematic issues around PLWHAs: The following thematic issues around PLWHAs were identified in *Involvement of people living with HIV/AIDS in Policy and Programme Development*, a study conducted for the UNDP Regional Project on HIV & Development for Asia and the Pacific:

1. The need for a better conceptual understanding of the place of the PLWHA in the national response. For most people working in HIV, and in most countries, there is no adequate conceptual framework within which they can apply and explore their efforts to encourage the greater involvement of PLWHA groups. This creates difficulties when advocating with policy makers to seriously consider initiatives in this area. It is difficult to shift people beyond seeing PLWHAs as patients in need of services; there are insufficient theories and models to use for arguing for a broader forms of understanding and response. While it is accepted that PLWHA involvement should occur, there is an urgent need to develop sophisticated analyses of why it is of benefit to focus upon the place of PLWHAs in, and their contribution to, the integrated response to the HIV epidemic.

2. Understanding PLWHA organisational development as a process, not a structure. PLWHA groups must be treated as processes, not as structures or vertical, single-focus programmes. Understanding that the coming together of PLWHA to achieve common goals is a process, which means that the dynamic it creates allows for evolution and change, and is more prone to evolve creative responses in reaction to local needs and contexts.

3. The diverse roles and responsibilities of PLWHA groups. In the west, PLWHA movements have been shaped around notions of empowerment, activism and openness about one's HIV status. There are major difficulties while transferring this model to other countries. Even in Thailand, where PLWHA groups are large and active, many PLWHA from the middle classes are uninvolved, and not because they have well-developed coping mechanisms of their own. The strong fear of social ostracisation that follows disclosure, the absence of any supportive or protective wider environment, the lack of sound, protective legal and health policies, are some of the reasons why many PLWHA hide from the public gaze.

4 PLWHAs as actors against the epidemic: It is necessary to develop and nurture PLWHA as players in the responses to the epidemic: not only as support or pressure groups but as resource people willing to speak or write publicly or anonymously, as members of decision making groups on the community, state and national levels, as people themselves trained in counselling to work with other's like themselves and to provide the insight that only they can have. In the words of one who has done such work with such groups: "It is a long, painful process that requires taking on immense responsibility for the welfare of others who accept to place themselves in the danger of the public eye... and yet the successes are the most stunning, the most moving, the most effective of any we have seen, and well worth the uphill battle."

5 The role of government and NGOs. The government has particular key responsibilities including providing political leadership, namely making PLWHA involvement a priority; allocation of funds, appointing PLWHA to decision-making bodies and facilitating their participation; conducting campaigns to reduce stigma and misconceptions which create a national and social context compatible with what PLWHA are trying to achieve at a personal, family and community level; and the creation of appropriate laws and guidelines.

The link between NGOs and PLWHA groups is particularly important in environments where the PLWHA is not active or being heard, or are still in the early stages of creating organisations. In such situations, the PLWHA's ability to express their needs and experiences in programme and policy forums will be low; NGOs could play the role of intermediaries or conduits at such stages in the process.

6. Developments in HIV medicine: Within western PLWHA communities it is now rare to hear of sickness, deterioration and death. Hospitals have had a massive decline in patient numbers. Many people who were invalids are now well, and PLWHA groups working to re-integrate them in the workforce and to plan for their future^{3s}.

This is in complete contrast to the experiences of PLWHA in developing countries throughout the Asia Pacific region. Many of them are well aware of these developments in the west but only a small percentage are in a position to access these new treatments.

Section Three

Working On AIDS

HIV/AIDS is one of the most urgent public health concerns today. But the prevention and control of AIDS cannot just be the sole responsibility of the health services. If we have to launch a successful campaign to combat the scourge of AIDS it is essential that different sections of society like media, NGOs, activists, policy makers etc. all get involved. Our knowledge about the disease and its control is continuously evolving and different areas of work are getting increasingly specialised. Despite all this specialisation and the complexity of the subject working on the issue of AIDS can be simplified to – working to prevent the spread of the infection, and working to reduce the physical, personal and social impact of the infection, and advocacy to mobilise national and international efforts against AIDS and to secure individual rights and entitlements for the affected. Some of the key features of each of these different approaches are being highlighted below.

Working on Preventing the spread of HIV-

Prevention of HIV infection remains the key to combating AIDS especially in a country like India where the infection remains relatively low, though the potential for spread is very high.

Box-

HIV/AIDS Prevention Package

- Promoting safer sex behaviour through education
- Condom promotion/provision
- STD diagnosis and treatment
- Safe blood transfusion
- Safe injecting behaviour

(Source-AIDS No Time for Complacency, WHO)

Information, education and communication (IEC)- IEC is a key to the prevention of AIDS, but what has to be kept in mind that the objective of this is to change behaviour, especially sexual behaviour. In order to have a successful IEC strategy one must be courageous enough to address issues of sexual behaviour within our society, a subject which is usually not discussed in the open. At the same time the subject must be approached in a manner which does not make people defensive or openly hostile. Today there are a host of IEC material on AIDS available in the form of booklets, flashcards, videos and so on. One must choose the material carefully depending upon the objective of ones programme.

Targeted interventions - This refers to activities targeted to specific population groups who are considered vulnerable. It includes providing information and services to these groups. Some of the specific population groups with whom targeted interventions are being made include commercial sex workers, intravenous drug users, truck drivers and so on. While working on targeted interventions one must not forget that the targeted population is not the only population at risk.

Two other prevention strategies include **control and treatment of sexually transmitted diseases and condom promotion and provision.**

Working on HIV/AIDS care and support

Care of the HIV infected person- Once the person starts developing the symptoms of the disease AIDS is a long drawn disease. It includes periods of intensive medical care interspersed with periods at home. Programmes have been designed which help health care providers and family provide better care to the infected persons.

Counselling- HIV/AIDS infection is a condition with profound emotional, social and behavioural consequences. In such a situation just providing medical care is not enough. The person who has the infection, or even may have the infection needs tremendous support, and this support can be provided through counselling. The role of counselling begins before taking an HIV test (pre-test counselling) and is an important part of therapy.

Positive persons support groups or PLWHAs - People living with HIV AIDS (PLWHAs) are important for the support of people with the infection. Their roles have been discussed in an earlier section.

Advocacy

HIV/AIDS has introduced new challenges to the defence of human rights. Clear laws need to be framed which protect the rights of persons with HIV/AIDS and to prevent discrimination against them. The different issues which need to be addressed have been detailed clearly in the earlier section.

National AIDS Control Programme - Box

The National AIDS Control Programme was initiated in India in 1987. This programme was designed to implement a preventative plan including health education and condom promotion among identified risk behaviour groups, and screening of blood and blood products. In 1991 a comprehensive nation-wide Strategic Plan for the prevention of AIDS in India was drawn up with focus on research, surveillance, IEC, control of STD, condom prevention and blood safety. The programme was for five years (1992-97) and was funded by a soft loan from the World Bank. By 1992 the National AIDS Control Organisation was started under the Ministry of Health and Family Welfare, and was responsible for implementing this programme. A widespread media campaign was launched on the press and TV. A newsletter titled AIDS in India was also started. NGOs were also encouraged to integrate HIV/AIDS into their ongoing work. And small funds were also provided.

In an effort to promote collaboration, the University Talk AIDS programme, a peer-education campaign for college goers was started with the Department of Youth Affairs and Sports. In collaboration with the NCERT an AIDS education training package was also developed for teachers. Besides this a number of other initiatives were taken up to study risky behaviours, improve quality of condoms, increase the skilled pool of counsellors and improving the quality of blood products.

Unfortunately this programme has still not been able to develop the sense of urgency about the problem and a sense of denial still persists in large populations within the country, and the number of positive people has continued to grow at an alarming rate. Now the second year phase of the programme (1999-2004), has been launched and it is expected that it will benefit from the previous experiences.

Some Innovative projects on STD, HIV/AIDS

There are a large number of organisations working on the different aspects of AIDS. Infact many organisations both Governmental and non-governmental have incorporated HIV/AIDS awareness within other programmes, be it health programmes, programme with adolescents or college goers. In other situations deliberate programmes have been designed to address the needs of commercial sex workers, truck drivers, industrial workers, youth and so on. An attempt is being made to provide a flavour of the different kinds of approaches being adopted by these organisations. Brief profiles of the work of four such organisations are being provided below.

STD HIV Intervention Project, Calcutta

This is perhaps the most well-known STD/HIV project in the country, and is also known as the Sonagachi Project. This project started as a prevalence study of STDs in a redlight district in Calcutta in 1992, but has since then has developed into a full fledged intervention. It was initially being implemented by the All India Institute of Public Health but is being currently managed by an autonomous committee which has sex-workers as members. The three main focal issues of the project include – sexual health services through clinics, education through peer educators and a campaign for rights of sexworkers through an organisation of sex workers.

For further details please get in touch with:

Ms. Mrinal Kanti Dutta (Director)

SHIP (STD HIV Intervention Programme)

8/2 Bhawani Dutta Lane

Calcutta-700 073

Phone 033-2415253, 2416200,2416283

Fax 033-2416283

E-mail- ship@cal.vsnl.net.in

AIDS Research Foundation of India,(ARFI), Chennai

ARFI was founded in 1991, with objective of promoting awareness around AIDS and work towards its eradication. It has worked with and is currently involved in working with sex workers, truck drivers as well as industrial workers. ARFI also organises clinics for STDs where HIV testing is also done. ARFI has also organised AIDS aware in villages by using the effective medium of street theatre.

For further information please contact:

Shobha Krishnan,

Field Officer,

ARFI,

20 C, Thirumalai Road (opposite Kamraj House),

T Nagar, Chennai –600017.

Naz Foundation, New Delhi

The Naz Foundation (India) Trust was established in 1994. The main focus of Naz Foundation revolves around the development of HIV/AIDS and sexual health services. Activities of the Foundation include-Training Programs (for schools, colleges, NGOs, hospitals), Healthy-Highway project (involving the mobile population of truck drivers), Peer education (college students have being trained in HIV basics, and skilled in information dissemination and pass on information to their peers, family and friends) and Consultancies related to HIV/AIDS.

For further details please get in touch with:

Ms Anjali Goapalan ,

Director,

The Naz Founation (Trust),

D-44, Gulmohur Park,

New Delhi-

Phones 011-686 2422,685 1970,685 1971

Email- anjali@naz.unv.ernet.in

JANANI, Bihar

JANANI, is different from the previous three in the sense, that its innovation lies in making available curative services for STDs and RTIs to women in the remote villages of Bihar. JANANI is involved in training Registered Medical Practitioners (unqualified practitioners of western medicine) to diagnose and treat these diseases using WHO's syndromic approach. The RMP works in partnership with a female member of his household who is trained in communication and interpersonal skills.

For further details of this project kindly contact:

Shri K Gopalikrishnan,

Director,

JANANI,

C-16 A, Sri Krishnapuri,

Patna- 800001.

RESOURCE SECTION

Further Reading: HIV/AIDS is a subject of considerable topical interest and there are a large number of books and newsletters on the subject. Some of the books that we have found useful in the preparation of this booklet are given below:

Abha Bhaiya and Ratna Kapur	1994	Report of the National Workshop on Women, STDs, HIV and AIDS, New Delhi, Jagori
Dept. of Youth Affairs and Sports	1993	National Workshop on Youth Action and AIDS, A workshop report, New Delhi
Elizabeth Reid	1993	Placing women at the centre of the analysis, New York, UNDP
Elizabeth Reid	1993	Sharing the Challenge of the HIV epidemic, New York, UNDP
Elizabeth Reid, Michael Bailey	1993	Young Women: Silence, Susceptibility and the HIV epidemic, New York, UNDP
Ellen Weiss, Geeta Rao Gupta	1998	Bridging the Gap: Addressing Gender and Sexuality in HIV Prevention, Washington, ICRW
John Hubley, Shankar Chowdhury, V Chandramouli	1995	The AIDS, Bombay, Popular Prakashan
Julie Hamblin	1993	People living with HIV: The law, ethics and discrimination, New York, UNDP
KIT, SAfAIDS and WHO	1995	Facing the challenges of HIV, AIDS STDs: a gender-based response, Amsterdam, Harare, Geneva
Maggie Black		AIDS and Asia: A development crisis, New York, UNDP
Marge Berer, T.K.Sundari Ravindran	1995	Reproductive Health Matters - Promoting Safer Sex, London, Blackwell Scientific
Moni Nag	1996	Sexual Behaviour and AIDS in India; New Delhi, Vikas Publishing House Pvt Ltd.
Sandip Bandopadhyay	1997	The Sonagachi Experience: An Intervention Project among commercial sex workers, New Delhi, VHAI
Sanjay Kapur and Jaiwanti P Dhaulta	1997	Handbook for Nurses on HIV/AIDS, New Delhi, Voluntary Health Association of India
UNAIDS/WHO	1998	India: Epidemiological Factsheet on HIV/AIDS and sexually transmitted diseases
Werasit Sittirai and Glen Williams	1994	Candles of Hope, London, Action Aid
World Health Organisation	1997	AIDS The Challenge, New Delhi,
World Health Organisation	1998	Clinical management of HIV and AIDS at the district level, New Delhi
World Health Organisation		Understanding and Living with AIDS, New Delhi
World Health Organisation	1992	AIDS Prevention

World Health Organisation	1996	Handbook on AIDS Home Care, New Delhi
World Health Organisation	1994	Lets Talk about AIDS, New Delhi
World Health Organisation	1995	Information, Education and Communication, New Delhi
World Health Organisation	1997	AIDS: No time for Complacency, New Delhi

Resource Organisations

There are a large number of organisations today which provide different kinds of resource support for NGOs wishing to incorporate working on HIV/AIDS in their work. This support could be in the nature of providing a library, publishing books videos, pamphlets and other material for distribution, providing financial support and so on .

The single largest resource organisation is the National AIDS Control Organisation (NACO) and the related State AIDS Control Organisations (SACOs). The address of NACO is given below:

Director NACO,
Indian Red Cross Building,
1, Red Cross Road,
New Delhi 110001.

Some of the International/UN bodies involved in working on the issue and from whom a large amount of material may be accessed include

World Health Organisation- SEARO
Indraprastha Estate
New Delhi -110002

UNDP
HIV/AIDS Regional Project
55 Lodi Estate,
New Delhi 110003

UNAIDS
C/o UNDP
55 Lodi Estate,
New Delhi-110 003

UNIFEM
228 Jorbagh,
New Delhi 110003

Some Voluntary Organisations which can provide support to others working on HIV/AIDS include:

Naz Foundation

(For address see above)

VHAI and the different State VHAs

VHAI,

40 Institutional Area, (behind Kutab Hotel)

New Delhi 110016

NGO AIDS Cell

All India Institute of Medical Sciences,

Aurobindo Marg,

New Delhi -110016

SPARSH

B -163, Indira Nagar,

Lucknow

221010. U.P.

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UNDERSTANDING
REPRODUCTIVE HEALTH

A Resource Pack

Booklet - Eleven

SEX AND SEXUALITY

Acknowledging Ourselves

SAHAYOG

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INTRODUCTION

The most pressing of human biological needs after hunger is probably sexuality. This is also probably the least talked about subject and the one which carries the biggest taboo. Religions, philosophies and legal systems - all concerned with shaping human behaviour, have typically tried to establish sexual values and taboos. It is still a subject about which not enough is known, and myths and misconceptions abound.

As talking about sex and sexuality in polite circles has been a taboo for a long time our language for talking about these is also very limited. It is especially difficult to talk about sex in Indian vernacular languages because most of the words available to talk about sex and sexuality are also abusive words. There is a schism between public discomfort and private obsessions about sexual issues. Being open about sexuality threatens people who can get away with sexual abuse and exploitation, including perpetrators of rape and incest. These people, among others, take advantage of the strict silence maintained on these issues.

However, things are changing now, and suddenly people are talking about sexuality everywhere. The most important reasons are the onset of AIDS and globalisation. Also, the International Conference on Population and Development (Cairo 1994) has introduced sexuality as an issue, to the development agenda. Consequently a lot of the taboo around the subject is also disappearing and new sexual mores are forming.

Unfortunately, there is still very little being done on the issue of sexuality. There is a serious dearth of available data on the various issues involved. The government is still hesitant to address sexuality, even though reproductive health has been the focus of government attention for the last 50 years.

In this booklet we shall look at some of the terms used and issues involved vis-a-vis sexuality, besides examining current debates surrounding the topic

Section One

UNDERSTANDING SEX AND SEXUALITY

Sexuality

The word sexuality has not been defined very clearly. The word 'sex' is generally used to mean male or female (biological gender) or to refer to physical activity involving the genitals (having sex). The word "sexuality" has a broader meaning since it refers to all aspects of being sexual. Every person has sexual feelings, attitudes and beliefs, yet each individual's experience of sexuality is unique, because it is processed through a uniquely personal perspective. Sexuality is a complex phenomena, and has several aspects. It includes the various ways of expressing sexuality and the various sexual preferences or dislikes that people have. Hence, sexuality has biological, psychosocial, behavioral, clinical and cultural dimensions.

Sexuality includes how one regards one's body and self-image and the manner in which societal norms affect the construction of the same, the way we communicate our sexual feelings and needs, what stands we take on matters relating to sex, the ethics and values that we uphold on sexual matters and so on. All these affect the way we see ourselves and others as sexual beings and how we express our sexuality.

Sexuality therefore has two dimensions — outward and inward. The outward includes perceptions of one's sexual needs and their expression of this. Inward sexuality includes one's own perception of sexual pleasure (or lack of it), sensuality, and the kinds of meanings we ascribe to our sensory perceptions.

Sexual Health

Sexual Health refers not only to the condition where there is an absence of sexual problems and dysfunctions, but also to the enhancement of the quality of sexual relationships and personal life. Sexual health is not limited by the mere understanding of reproductive abilities but goes further to include the ability to experience a pleasurable and affirmative sexuality. Sexual health is women and men's ability to enjoy and express their sexuality, and to do so free from risk of sexually transmitted diseases, unwanted pregnancy, coercion, violence and discrimination. Sexual health means being able to have an informed, enjoyable and safe sex life, based on self-esteem, a positive approach to human sexuality, and mutual respect in sexual relations. Sexual health enhances life, personal relations and the expression of one's sexual identity. It is positive, enriching, includes pleasure, and enhances self-determination, communication and relationships.

Sexual health is fundamental to the development of one's full human potential, to the enjoyment of human rights and to an overall sense of well-being. By endorsing sexual

health for all - legal, health and education systems build a strong foundation for preventing and treating the consequences of sexual violence, coercion, and discrimination.

Sexual Anatomy

Sexual anatomy is usually thought of as including the various reproductive organs like the vagina, clitoris, breasts and anus in women, and the penis, testicles and anus in men. However, in reality, the entire human body is capable of receiving and giving sexual sensations. This includes our hands, hair, eyes, skin, mouth and every other part of the human body.

Puberty

Puberty is the phase of adolescence in which boys and girls begin to develop the sexual and physical characteristics of adults. Puberty can start as early as 8 years in girls and 10 years in boys. In boys these changes are triggered by increased production of the male sex hormone called testosterone. In girls these changes are triggered by the production of the female sex hormone known as estrogen. Every young person's biological timetable is different, and wide variations regarding the beginning and end of puberty are quite normal. While infants and children also have sexual feelings, these are not developed and conscious. Puberty is the time when boys and girls begin to take a definite interest in sexual relations and start experimenting with some form of sexual behaviour.

Social construction of sexuality

The social construction of sexuality refers to the process by which sexual thoughts, behaviours, and conditions are interpreted and ascribed cultural meaning. This third element incorporates collective and individual beliefs about the nature of the body, about what is considered erotic or offensive, and about what and with whom it is appropriate or inappropriate for men and women to do or talk about sexuality. In some cultures, ideologies of sexuality stress female resistance, male aggression, and mutual antagonism in the sex act; in others they stress reciprocity and mutual pleasure.

The social construction of sexuality is inevitably linked with cultural concepts of masculinity and femininity. Ideas about what constitutes the essence of "maleness" and "femaleness" are expressed in sexual norms and ideologies. Cross-cultural studies reveal that, the imagery of manhood in most societies is a "culturally imposed ideal to which men must conform (often at great cost to themselves and to others) whether or not they find it psychologically congenial". This is also true for females as they must conform to ideas of "womanhood" within a particular culture. In our own culture, a familiar script that has been constructed to guide female sexual behaviour places emphasis on virginity and chastity for the woman. This construction in turn impacts the self image and behaviour patterns of many women.

The contradictions of male power and sexuality are expressed in men's efforts to dominate women, which derive from male physical, material, and ideological advantage and in their anxieties about failure and loss of face. Sexual potency is equated with men's authority over women; thus, attacks on potency threaten male power, and vice versa.

Sexuality and Reproductive Health

Women's reproductive health as we know it today is based on the principle that every woman has a right to reproductive health, that is, not only the right to regulate her fertility safely, remain free of disease and bear healthy children, but also to understand her sexuality. It further recognizes that rights to sexual as well as reproductive health are vital elements of physical and emotional well being.

A woman's ability to negotiate during sexual intercourse affects safeguarding of Reproductive Health in many ways. This negotiating power depend on a lot of factors including her self-esteem, social construct of sexuality and empowerment of the woman. Women in India, largely, lack all of these factors, making them highly vulnerable to unwanted pregnancy, STDs, AIDS and other infections.

The fact is that women are not allowed to be sexual in mainstream Indian society. They are brought up to feel ashamed of their own bodies, which only results in low self-esteem. The social constructs that determine the scope of female sexuality, force women to repress their sexuality until they get married. Then suddenly one day the woman is expected to surrender completely to a husband – who is in effect a stranger, who will from now on control her sexuality. In this situation, she is unable to negotiate during sexual intercourse thus leaving her vulnerable to unwanted pregnancy, infections and forced sex.

Conditions surrounding sexual initiation have particular importance in shaping attitudes and behaviours, including long-term reproductive and health outcomes. According to research, girls who have experienced sexual abuse as children are more likely than others to have early first intercourse and more sexual partners as adolescent and young girls. They are also more likely to have unintended pregnancies and STDs including HIV.

In the given situation where a woman's sexuality is incumbent on marriage and facilitated if not defined only by her husband, marginalised women like Commercial Sex-Workers are looked down on by society as immoral for being visibly sexual. They are seen as a threat to the health of their male clients, while their own reproductive health is ignored. Since Commercial Sex Workers have no rights in this society and are seen as sub-human beings. it is easy to ignore their reproductive health rights.

One reason why the family planning programme has not been so successful in India has been because the issue of sexuality was never addressed when talking about reproductive health. Many men for example do not like to use condoms, even when they have all the information, because they feel it reduces their sexual sensations.

Common Sexual Problems: Sexual disorders and dysfunction

1. Sexual dysfunction in men

Loss of Sexual desire - Loss of Sexual desire or libido may be due to different reasons, including psychological and other factors such as stress, anxiety, fatigue, misdirected sexual desire, etc.

Impotence and Erectile Failure - It is the failure to achieve an erection. It is a common problem faced by men. Almost everyone goes through a phase when he is impotent. The most common causes of erectile failure are psychological (e.g. anxiety), neurological disorders, impediments in the blood flow (e.g. vascular disease), hormonal deficiency, penile infection, diabetes, etc.

Premature Ejaculation - Premature Ejaculation is a very common problem, especially amongst younger men. The condition can be defined as an inability to delay ejaculation to a point when it is mutually desirable for both partners. This duration can vary for different men. Most causes of premature ejaculation are psychological in nature (e.g. anxiety) but some cases are due to physiological reasons. (CAN WE ELUCIDATE?)

Delayed Ejaculation - Some men can not ejaculate soon enough. This problem though not so common can be as distressing and can make sex unpleasant. This problem also has psychological as well as physiological reasons. (CAN WE ELUCIDATE?)

Painful Intercourse - There could be numerous reasons why a man has pain during intercourse including a tight foreskin, lesions on the penis, blisters caused by herpes and diseases like Peyronie's disease.

2. Sexual dysfunctions in women

Lack of sexual desire - Lack of desire is a very common sexual problem amongst women. It can have a physical cause, such as chronic illness, drugs, etc. or (more often) psychological causes like guilt, anxiety, depression, etc. Counseling and sex therapy can help find out the causes and getting over them.

Painful intercourse - This is also known as dyspareunia and is mostly due to physical reasons like a vaginal irritation or infection, an allergic reaction to a douche or a contraceptive product due to which movement of the penis inside hurts. Sometimes there is a psychological reason for painful intercourse like when she is not getting aroused. In such cases, her vagina may not lubricate, and intercourse will be painful.

Anorgasmia - It is the inability of a woman to achieve orgasm with a partner. The main cause is due to sexual illiteracy on the part of both the woman and

her lover. It could also be due to religious and social prohibitions that have precluded learning orgasmic responses through masturbation. Anxiety (e.g. caused by eagerness to achieve orgasm) can also impede with orgasm.

Preventive and curative aspects of sexual health

1. Sex education - Sex education for young people and adolescents was an unthinkable topic in India just a decade ago. A lot has happened since then, and there is a growing general consensus at least in big cities in India, about the importance of sex-education. The single most important factor in this change of attitudes is the spread of AIDS and the growing realisation of the vulnerability of young people. Though there is some agreement on the need for sex education, the exact content and the age from which it should start, are still topics of hot debate. Some people believe that sex education should stress biological and physiological facts, while others feel that morality should be the core content of sex education. On the other hand some argue that sex education should include awareness of needs, desires, autonomy and responsibility. There are still others who want students to learn about only that part of AIDS awareness which does not concern sex.

2. Counseling - Counseling on sexuality refers to guidance provided to an individual or couple by a sex therapist, counselor, social worker, psychiatrist, or doctor on such questions as conception, family planning, infertility, fear of failure in performance, unresponsiveness, sexual anatomy and physiology, techniques of intercourse, AIDS/HIV, STD's etc. It is a new concept in India.

3. Sex Therapy - Until recently, in the event of a sexual problem, the majority had nowhere to go. Taking advantage of this, numerous unscrupulous sex clinics erupted all over India. These clinics offered all kinds of cures, including magico-religious cures, for perceived sexual problems (which are in fact, not problems at all) like masturbation and pre-ejaculation. Their clients are mostly men. Women have nowhere to go in case of a sexual problem. Even today, these sex clinics thrive, but in some big cities there are now sex counsellors and therapists as well. (add)

Different forms of sexuality and gender

In this section we describe those forms of sexuality which are defined by the person or object which is perceived as sexually attractive or arousing, e.g. homosexuality, where a person is attracted to someone of their own sex. This classification of sexuality is not the most appropriate one. But it is the single system which society is preoccupied with. Defining sexuality with reference to the sex it is directed at and then building whole identities around them, complete with labels and stereotypes, is a typical western phenomena. It presents a highly limited view of sexuality and only serves to discriminate, stereotype and discourage or punish that which society can not come to terms with. Sexuality is much more fluid in India and usually does not limit an individual's identity to one particular stereotype.

A. Heterosexuality, homosexuality and bisexuality

Heterosexuality: Heterosexuality is the sexual attraction between people of the opposite sex, i.e, male and female. In the west people who consciously choose to live such a lifestyle are called heterosexuals. Though rights for people opting for other sexual identities are increasing, this is the only identity which is consciously and aggressively promoted as the ideal form.

Homosexuality: The sexual attraction or activity between two or more people of the same gender is known as Homosexuality. In the west homosexuals refers to that group of people who consciously choose to take on a homosexual identity and lifestyle.

Bisexuality: The sexual attraction or activity towards people of both male and female sexes is known as bisexuality. Many psychologists believe that human beings are born bisexual and that most of us stay that way in combinations of heterosexuality and homosexuality, whose ratio may alter from one time to another. However, given the extent of homophobia in society at large, most of us try to suppress and deny the homosexual aspect of our personality, and thus appear to be largely heterosexual.

Homophobia: Homophobia refers to an illogical fear or hatred of homosexuality. Institutionalized homophobia can manifest itself in policies and laws that seek to exclude, punish or discourage people who practice homosexuality. Internalised homophobia manifests itself in feelings of guilt, self-hate and suppression of the homosexual aspect of our personality, while externalised homophobia represents hostility towards or ridicule of others who practice homosexuality, including by homosexuals themselves. Homophobia in many parts of the world is an integral part of the social construction of male sexuality.

B. Transvestitism, cross-dressing and Transsexualism.

Transvestites: Transvestites are people who derive sexual pleasure from wearing the clothes of the opposite gender. Female transvestites are not very visibly in society and are therefore left alone. Male transvestites usually wear feminine clothes in private. Some may wear them in public and may then be mistaken for women. Transvestites may be heterosexual, homosexual or bisexual. In many areas in India ritual transvestism is accepted on social and familial levels

Cross-dressers: Cross-dressers are people, who like to wear the dresses of the opposite gender, and there may be no sexuality involved here..

Transsexuals: Transsexuals are people who believe that they are born with the wrong sex. E.g. a female transsexual may feel she is actually a man with a female body. Transsexuals frequently describe their dilemma as 'being trapped in the wrong body'. Surgery can change the outer sexual organs, but they cannot function as reproductive organs

C. Hijras

Hijras are a community of people in India, mostly men, who are transvestites, transsexuals, cross-dressers or hermaphrodites. Contrary to popular belief only 1-2% of Hijras are hermaphrodites and not all Hijras are castrated. There is very little information available on Hijras, and it is a community that has been largely neglected. Hermaphrodite children are taken by Hijras as soon as they are born, as almost a matter of traditional right. The rest of them join the sect either in their adolescence or as adults. Only the transsexuals opt for castration, though it is allegedly forced on some men.

Hijras practice a range of sexual activities with men or women or both. In the olden days Hijras had a certain place in society and they were assumed to have supernatural powers. They were invited to weddings and childbirths to bless the couples or the newborns. But today, their main livelihood besides singing and dancing at family events, is prostitution. They do not have any rights in modern India. Because they are now so marginalised, some segments of the community have been criminalised. It should also be noted that anal intercourse which is widely practiced by the Hijras is a punishable crime in India, though it is unlikely that anyone would harass them, as they are known to become obscene and even violent when confronted.

Because of their involvement in sex-work, they are potentially at risk for HIV/AIDS. There is no evidence of any organised HIV prevention work being conducted with the Hijras.

D. Paraphilias

Paraphilia is a condition in which a person's sexual arousal and gratification depends on a fantasy theme or an unusual sexual experience that becomes the principal focus of sexual behavior. It can revolve around a particular sexual object (e.g. animals, underwear) or a particular sexual act (e.g., inflicting pain, making obscene phone calls). Paraphilia is distinguished from sporadic sexual experimentation in that it becomes an addiction, and is essential for the victim to reach orgasm. While some examples of paraphilia may appear foreign to most people, other examples are commonly found in watered-down versions, e.g., many people get sexually aroused by very explicit sexual language, others by watching their partners undress or making their partners undress them. Some common examples of paraphilia include fetishism, transvestitism, voyeurism, exhibitionism, obscene telephone calling, sadism and masochism, zoophilia, etc.

Section Two

ISSUES AND DEBATES IN INDIA

1. Human rights and sexuality

After a brief period of openness witnessed in Indian society, there has recently been a significant conservative backlash, against the surfacing of “sexuality” issues. Disturbing instances have been witnessed in the recent past. M.F. Hussain being hounded out of the country for painting a nude Saraswati, a sanyasin harassed for praying clothless, hooligans coming to the street against the screening of the film ‘Fire’ which explores a lesbian relationship, a programme giving information on AIDS and sexuality called “Kam ki baat” taken off the air by the government for being “against Indian moral values”. And these are just a few examples of a concerted effort to limit human expression.

Sexuality has never been acknowledged as a human rights issue in Modern India. Indeed there are repressive laws against many forms of sexual behaviour which in various advanced countries have become lawful. Marginalised communities like sex-workers or gay and lesbian people are not considered fit to have any rights and thus live on the fringes of society.

As the concept of human rights gets more firmly entrenched in the minds of the Indian people, as they get more and more informed, and as their financial independence increases, more and more people are now getting aware of and demanding their rights as sexual beings. This includes the right to practice with dignity the so called alternative forms of sexuality, that is, those forms which fall outside the heterosexual, monogamous marriage norm.

Indian History and Sexuality

Ironically, India was once a place, which led the world as a far seeing and liberal country. Ancient India was surprisingly open on issues related to sex and sexuality. We have innumerable temples depicting erotic images of all kinds of sexuality practiced by both ‘gods’ and ‘humans’. The Linga, or the Phallus of Shiva is worshipped till date by Hindus as a sacred power. Garba Grihas and Yoni temples, representative of the Vulva, have been abundant in the past. Kamakhya in Assam and the Bhagawathi temples in Kerala are living proof of the value ascribed to the Yoni. (That they are now fewer in number, has more to do with patriarchy than repressive sexual codes) It is a fact that Indian culture never shied away from the sexual and cthonic. The Kamasutra, a document on sexual techniques, practices and codes, which is still looked at with awe by the West, was written by Vatsyayana in ancient India. It is not a co-incidence that this was also the golden period of Indian History, where women had more rights than ever.

Heterosexuality the only acceptable form of sexuality

This is the only form of sexuality which is accepted as natural and healthy in our society. Specifically, heterosexuality *within marriage* is the idealised and accepted norm. There is a big social gap between men and women in our country. Gender roles are clearly defined

and interaction between the sexes is usually not regarded with glee. Therefore, it is not easy for young men and women to relate to or communicate with each other, and any interaction on the sexual plane is often purely physical, sometimes even within marriage. Society at large does not appreciate a man and a woman, who are not related to each other, to even be seen together in public. In this way, heterosexuality outside marriage is actually discouraged and suppressed, which makes the Indian sexuality scene a bit complicated.

In most parts of India, even today, arranged marriages are common and sexual compatibility is the last thing considered when fixing a marriage. Instead, emphasis is placed on caste, social position, income and dowry. And because marriages are expected to be a 'once and for all affair', divorce rates are very low, despite incompatibility. Thus women in such situations are suppressed socially and sexually. Because of the cultural construct, men have relatively more opportunities and freedom to develop extra-marital affairs or to visit sex-workers.

The scene is gradually changing in bigger cities, with more and more young couples opting for 'love-marriages'. However, given the big social divide still strictly maintained between men and women, there are not enough opportunities for them to meet each other in appropriate social settings. As a result an increasing number of men and women are leading lonely lives either because they do not want to get into an arranged marriage situation, or because it is not working for them. Furthermore, in many families, since girls are not allowed to interact with boys when they are actually thrown into mixed gender social settings at college or the workplace, they are often unable to discern right from wrong and end up making the wrong sexual/marital decisions.

Coming to heterosexual act; vaginal intercourse between two married people is socially considered the only honorable sexual act, and any other form is discouraged. Masturbation is shrouded in taboo and all manner of guilt is associated with it. There actually exists a law against anal and oral intercourse, with life-imprisonment as the sentence, even though it has never been used against a heterosexual couple (and rarely against homosexual ones). A wife can sue for divorce if she can prove that the husband had anal or oral intercourse with her.

Thus in a typical marriage situation, if the husband wants anything other than vaginal intercourse, he would not dare defy the sanctity of his wife. He would seek it from other sources such as sex-workers, male partners or Hijras. And by the same yardstick, the wife would not seek any pleasure, discuss her needs or make any requests of her husband. She would merely suppress or sublimate all her desires, since outside pleasure providers are limited in her case because of the constraints of her gender. Ofcourse, very often the husband would probably ignore the sanctity of his wife and plough on with happy disregard for his wife's feelings.

Homosexuality

Being an integral part of human sexuality, homosexuality has existed in all societies and in all times. However, it has been violently suppressed for centuries in many parts of the world, the root of which can be traced to the beginning of the Judeo-Christian-Islamic religions. Most ancient societies accepted homosexuality and even today in many societies it is accepted, even expected in certain forms. Today, worldwide, homosexual men and women have to fight for their basic rights and dignity.

In ancient and medieval India, though there were no special rights for homosexual people, homosexuality was not punished or suppressed by the state, society or the religion. The British brought with them their distaste for homosexuality and enacted a law against anal intercourse (which was their limited view of homosexuality). This law (Sec. 377, IPC) is still used by authorities to harass gay men in India. Many organisations view this law as a violation of human rights and a court case is being fought against it. There have been many instances of homosexuality both male and female in Indian history and mythology. Babur, Alexander the Great, and Sharmad Shahid are some of the people whose written accounts of loving other men can be found. Many ancient temples, including Khajuraho have depicted male and female homosexuality. Even the ancient Indian sutras on the art of love-making talk of homosexuality.

Today there is a strong social stigma attached to homosexuality in India. Indeed, most people believe it does not exist in India and is a Western phenomenon. Amongst several other myths and misconceptions that abound regarding homosexuality is that it is unnatural, abnormal or a disease, or that people are made homosexuals by others, or that male homosexuality reflects the effeminate part of a man, while female homosexuality represents a masculine female.

The biggest and most effective way in which a society suppresses homosexuality is through what is called the 'conspiracy of silence', i.e., by not allowing any discussion on the subject. Many gay and lesbian people in India live in closets and/or are married. Such marriages spell trouble for both partners. Other problems frequently faced are ridicule, low self-esteem and guilt – all of which are perpetuated by mainstream messages which do not allow for any behaviour outside of the heterosexual marriage norm. Many gay and lesbian people perforce hide their sexuality and pass off as heterosexual which is mentally and emotionally taxing. Many others isolate themselves in order to avoid such pretense. Finding a partner is extremely difficult for most, as there are almost no opportunities for gay people to meet each other socially. Gay relationships, when they do occur, are greatly tried because of the absence of any support system. The problems a gay or lesbian person faces are compounded by the fact that they cannot talk about their sorrows or happiness with any other person, not even their close friends and relatives.

Adolescence is the time when one's sexuality develops and it is normally a tumultuous period. Most homosexuals become aware of their homosexuality during adolescence. Dealing with one's homosexuality and a hostile society during one's adolescent, without any help, can be a truly traumatic experience which can stay with the person for the rest of his or her life. Many men and women commit suicides in India every year with causes

related to their homosexuality. Many among them are adolescents. According to a report on such suicides in Kerala, the cause for their suicide in most cases is not reported. Some men visit special places which are used by gay men for cruising (a term which refers to finding sexual partners in public places), such as parks and other busy places. Such men are routinely harassed by unscrupulous policemen who extort money and often 'rape' their victims. Lesbians do not have any place where they can find such partners. Homosexual people in India face these and innumerable other problems in silence. There is a great discomfort in all sections of the society (including the state and the media) in dealing with the issues of homosexuality in a non-stereotypical and comprehensive manner.

However, there is a bigger and very immediate problem that cannot be ignored. AIDS is spreading fast in India and unprotected penetrative sex between men is one potential route of HIV transmission. Ofcourse the same is true of unprotected penetrative sex between any combination of partners who are not aware of each other's sexual history, but because of the vulnerability of anal membranes to lesions gay men are considered particularly at risk. Unfortunately, any initiatives to deal with this problem have come from the private sector and the authorities are highly averse to addressing the issue. According to NACO figures there is negligible HIV transmission through homosexual routes in India.

Many gay and lesbian support groups have come up in major cities in India which on one hand are trying to help gay and lesbian people build an indigenous gay and lesbian identity, and on the other are trying to fight social oppression. Many non-gay/lesbian organisations are also working with homosexual people through counseling, AIDS networks and other community based work etc. They are also disseminating information about homosexuality in the general public to reduce the stigma attached to the issue.

There are not many statistics available in India regarding the instance of homosexuality. Whatever is available, is mostly on male homosexuality and hardly anything on female homosexuality. There is a huge need to carry out both qualitative and quantitative studies in this field.

(a) Male Homosexuality

In India male homosexuality has a peculiar position. While on one hand there is a lot of hidden sex amongst men in the form of bisexuality, as long as it is not talked about and made into an issue, society also condones it. On the other hand, there is a strong stigma attached to total "out" homosexuality. The important issue here is marriage. If one gets married and carries on a hidden homosexual life, it is no problem to the society. However, choosing not to get married and openly professing a homosexual life-style is a big problem.

(b) Female homosexuality

While male homosexuality has from time to time received attention, albeit negative, from society, female homosexuality has largely been ignored. It follows from the same

misconception that assumes that females are not sexual beings. Female to female sex is also ignored because many people cannot comprehend sex without penetration. Female homosexuality had not in the past met with such violent disapproval as male homosexuality, though this is fast changing. Lesbianism has always existed in India as in other societies. There are ample instances of it in our art, history and mythology. There have been several reported cases of two women marrying each other or committing suicide together. Women's institutions like schools and hostels inevitably have one or more women who stay together as couples. Many lesbians in India have been active for decades in the women's movement, and many sections of the women's movement have supported and promoted the rights of lesbians.

Crime and sexuality

1. Child Sexual Abuse

There is a high incidence of child sexual abuse and incest in our society. Unfortunately its existence in our society is not readily accepted. Its prevalence is slowly beginning to emerge as a result of work that has been done over the last few years. Also the taboo on the subject is losing its hold and more and more cases are now being reported. Most abusers of children are family members, relatives or someone known to the victim. Most abusers are people whom the child trusts and who enjoys power or authority over the child.

Research has established that child sexual abuse happens in a range of Indian families coming from all socio-economic groups. Abusers are people we encounter everyday in our families and amongst our friends. *Children never cause or provoke the abuse.* The abusers depend on the silence that surrounds sex and in either overt or covert ways, convey to children the message that the abuse should be kept a secret.

2. Rape

Rapes are most often committed by acquaintances, not by strangers, as is commonly believed. It is not random, but a pre-meditated act on the part of men. There is a strong misconception in society that ascribes women's immodest and provocative dress and the secret sexual longing of women to be raped, as reasons for rape. Rape victims are usually made culprits by both society and the law. Most rape victims do not want any publicity because they fear humiliation and rejection by the family. If the woman is ready to take the publicity, the legal process in itself is a sad and frustrating story.

The police, armed forces and para-military forces often misuse their position of authority with impunity and commit sexual violence and rape against women. Custodial rape is also common. What is surprising is that they are often set ~~scot~~ free by the courts, which reflects the need for a drastic changes in our laws.

3. Eve Teasing and Sexual Harassment

Almost every woman in India has been sexually harassed at some point or the other. The "lesser" form or rather the more routine form of sexual harassment is referred to as "eve-teasing". Eve-teasing as a behaviour is actually glorified in Indian cinema which has a great influence on the Indian psyche. In most cities men take advantage of crowds to harass women. A general attitude of "boys will be boys" makes sexual harassment out to be an innocent or frivolous activity.

Sexual harassment at work is even more serious. It often spells demoralisation, loss of professional confidence and even unemployment. There are no studies in India which give an estimate of the extent of sexual harassment at the workplace. Women are made the targets of unnecessary physical contact, deliberate verbal abuse or, in no uncertain words, asked for sexual favours. Workplace harassment like street harassment is a display of power. If refused the employers/ bosses will either make life difficult for the employee or simply find excuses to fire them. Complaints to higher authorities are usually unheeded. There is a general feeling amongst employers that if women have dared to come out to work they should be able to "handle" such "minor" problems by themselves. Low or no income women are particularly vulnerable to sexual harassment, because the alternatives are even more bleak.

Women who move in 'public spaces' are perceived to be transgressing the boundaries of female propriety and are therefore considered a sexual provocation, to be teased, harassed or assaulted. In a society where family honour is linked to the virtue of its female members, sexual harassment and rape are often used in property feuds and factional disputes to humiliate opponents.

In Indian society gender inequalities are very high. Like any other society where sexual issues are taboo, people do not enjoy sexual rights and therefore suppress their sexuality and further perpetuate gender imbalances through various displays of power. This results in a system that might be prone to incidences of sexual crimes like those of child sexual abuse, rape and sexual harassment

Section Three

WORKING ON SEXUAL HEALTH ISSUES

Sexual health is emerging as one of the new areas of concern in all sectors- Research, Advocacy or Service provisions. There is a great lack of proper information or documentation about sexual health issues and myths and misconceptions about. Education on sexual health for different sections of the public is also one of the key emerging issues. Unless public education takes place numerous people will continue to suffer, unaware of the nature of their problems and ignorant about the measures they could possibly take. Some of the key areas for future interventions are outlined below.

Research

There is a acute shortage of information and data on sexuality and sexual health. For one the issue has been shrouded in morality as well as myths. Thus there is hardly any information about sexual behaviour and practices, dysfunctions and problems of the people in our country. Small beginnings have been made by different institutions in trying to understand these. There is a great urgency for more information on these issues especially with the AIDS epidemic looming over our country.

Education

Women, men, adolescents and children need to be educated about positive self-identity, self-esteem, decision-making and relationships based on equality and respect in addition to basic information about sex and sexuality including reproductive health, STDs AIDS and HIV. They should also be made aware about gender equality and acquire respect for diverse forms of sexual expressions and life-styles. Unfortunately whatever little information is distributed to the public on sexual health mainly relates to diseases. All the other important aspects of sexual health, e.g. those that promote healthy sexual relationships and help one enjoy a satisfying sexual life are often ignored. Another area of concern with regard to sexual health education is the moralising that is often done in the name of education. All sexual health educators must be extremely cautious in this regard.

Services

Good quality, respectful and confidential sexual health care throughout the life-span should be provided. Such care should be responsive to user needs and confidential. It includes providing counselling, clinical services for STDs, HIV, AIDS, sexual dysfunctions and problems, sex therapy, etc. It also includes supportive and active response by health care providers to suspected and actual instances of sexual abuse and violence. There should be an efficient referral system and respect for ethical and quality standards.

There is also need to do work to promote safety in sexual relationships. The safety

referred to here has many aspects. It includes safety from sexually transmitted infections, including AIDS and HIV, safety from unintended pregnancy, safeguard from harmful social or religious practices like genital mutilation of women (e.g. amongst bahai's in Bombay), or of men in the Hijra community, etc.

Media

The media should promote positive and diverse portrayals of women's and men's sexuality, sexual relations based on mutual respect and autonomy, promote diverse and diverse male and female images which highlight power sharing behaviours. It should develop campaigns on sexual health issues, e.g., violence against women, sexual violence and abuse and harmful sexual practices including female and male genital mutilation

Laws and Policy

Legal aid services to inform men and especially women (including girls) of their human rights and legal rights need to be provided. All legal, regulatory and social barriers to access to information and good quality health services, including age and marital status restrictions and other forms of discrimination need to be removed. Legislation which prohibits discrimination on the grounds of sexual orientation and protects the human rights of people who are so discriminated against need to be developed and enforced. Similar provisions to ensure a full range of sexual and reproductive health services should be legislated. Legislation that protects girls and women from violence by criminalizing rape, including rape in marriage and in situations of armed conflict, incest, sexual exploitation and trafficking, female genital mutilation, infanticide and gender-based genocide should be formulated. The human rights of all people regardless of health status or disability including HIV/AIDS through legislation which prohibits discrimination should be ensured.

Organisations working on Sexual Health and Sexuality

As mentioned earlier there are now a number of organisations that have started working on the issues of sexual health and sexuality. An attempt is being made here to acquaint the reader with the work of some of these organisations.

IFSHA

IFSHA is a non-governmental organisation working on sexuality, gender and sexual violence through counseling, training research and awareness raising programmes. IFSHA began in June 1998, though it was working previously as part of SAKSHI, a violence intervention centre in Delhi.

For further information please contact :

Ms Jasjit Purewal,

Interventions for Support Healing and Awareness (IFSHA)

J-39, First Floor,
South Extension Part I,
New Delhi -110049
Email- seher@del3.vsnl.net.in

TARSHI (Talking About Reproductive And Sexual Health Issues)

TARSHI is a telephone helpline which was initially started to provide assistance for their reproductive health related questions. In practice a large proportion of callers are men and TARSHI also provides counseling services and information on sexual health over their helpline. TARSHI aims to make peoples' sexual and reproductive lives more respectful and free of fear, infections and diseases. They believe that decisions related to ones sexual and reproductive lives are greatly affected by sexuality and realities of life. Not only this these decisions in turn affect the life. Tarshi works for the exploration of options in reproductive and sexual lives. Though they see women as their primary group of concern yet they reach out to every class, community, age group and people of various sexual preferences.

For further information about their work kindly get in touch with

Ms Radhika Chandiramani

Talking about Reproductive and Sexual Health Issues (TARSHI),

49, Golf Links, 2nd Floor,

New Delhi 110003

Phones – 011-462-2221, 4624441

Email-radhi@unv.ernet.in

The Naz Foundation (Trust)

While AIDS is the main focus of Naz's work, they are also involved in working on sexuality related issues. They are involved in conducting awareness campaigns for women, address Lesbians and homosexual men through the support groups and helplines. They have also produced a manual on sex and Sexuality.

For further information about their work kindly contact:

Ms Anjali Gopalan

The Naz Foundation (Trust),

D-44, Gulmohur Park,

New Delhi-

Phones 011-686 2422,685 1970,685 1971

Email- anjali@naz.unv.ernet.in

STD HIV Intervention Project (SHIP)

This project is primarily working on STD/HIV prevention and clinics in the Sonagachi red-light district in Calcutta. The unique aspect of this project includes a committee of commercial sex workers which is involved in campaigning for sex workers rights. This committee also includes male sex workers.

For further details kindly contact
Ms. Mrinal Kanti Dutta (Director)
SHIP (STD HIV Intervention Programme)
8/2 Bhawani Dutta Lane
Calcutta-700 073
Phone 033-2415253, 2416200,2416283
Fax 033-2416283
E-mail- ship@cal.vsnl.net.in

RAHI

Recovering and Healing from Incest (RAHI) is a support centre for women surviving incest and is dedicated to providing a variety of services in this area. RAHI's objective is to make women aware of the nature of incest and its consequences in each women's life. The organization also tries to break the silence that exists around incest and to talk about the way it happens in our society.

Ms Anuja Gupta

Recovering and Healing from Incest (RAHI),
M-79, Greater Kailash-II, 2nd Floor,
New Delhi 110048
Ph- 011-6238466,
Email – rahisupp@del2.vsnl.net.in

RESOURCE SECTION

Further Reading

Given below is a list of books and journals that we found useful in preparing this booklet.

1. Boston Women's Health Book Collective, The. 1998. *Our Bodies Ourselves* New Century. New York: Simon and Schuster.
2. Carrera Michael A.; 1995; 'The Wordsworth Dictionary of Sexual Terms'; New York - Wordsworth Editions Ltd.
3. Dastur, R.H. 1989. *Sex and Diseases*. Bombay: Popular Prakashan Pvt. Ltd.
4. Devi Shakuntala; 'The World of Homosexuals'
5. Donniger Wendy; "Women, Androgynes and other Mythical Beasts"
6. Dworkin Andrea; 1995; "Intercourse"; New York; Free Press Paperbacks.
7. Family Federation of Finland, The. 1998. *The Evolution of Sexual Health in Finland How We Did It*. Finland: The Family Federation of Finland.
8. Gandhi Nandita, Nandita Shah; 1993; "The issues at stake — theory and practice in the contemporary women's movement in India"; New Delhi: Kali for Women.
9. Germain, G. 1984. *Sex and Destiny: The Politics of Human Fertility*. New York: Harper and Row.
10. John Mary E. and Janaki Nair (eds.) *A Question of Silence*.
11. Kabeer Naila; 1996; "Reversed Realities — gender hierarchies in Development thought"; New Delhi; Kali for women.
12. Kakkar, Sudhir. 1989. *Intimate Relations: Exploring Indian Sexuality*. New Delhi: Viking.
13. Masters William H., Virginia E. Johnson, Robert C. Kolodny; 1995, "On Sex and Human Loving"; Bombay - Jaico Publishing House
14. Nabar, Vrinda; "CASTE as Woman"
15. Niranjana, T. 1994. *Femininity, Indianness and Modernity*. New Delhi
16. Paglia Camille; "Sexual Personae"
17. Ranganathan, N. 1994 *Puberty, Sexuality and Identity: A Psychological Analysis of Urban Adolescent Girls*. New Delhi.
18. Sabala and Kranti; "Na Shariram Nadi"
19. Selverstone, R. 1996. *Now What Do I Do?* New York: SIECUS.
20. Shephard Bruce D., Carroll A. Shephard; 1990; 'The Complete Guide to Women's Health'; New York - Penguin Books USA Inc.
21. Singh Renuka; "Womb of the Mind" and "Women reborn"
22. Thadani Giti; "Sakhiani"
23. Wellings Kaye; 1986; "First Love First Sex — a practical guide to relationships"; Northants, U.K.; Thorsons Publishing Group Ltd.
24. Westheimer Ruth; 1994. *Dr. Ruth's Encyclopedia of Sex*. New York: The Continuum Publishing Company
25. Zeidesnstein Sondra and Kirsten Moore; 1996; "Learning about Sexuality -- a practical beginning"; The Population Council Inc.

Journals

Sexuality', Reproductive Health Matters, Volume 6, Number 12, November 1998.
VOICES, Exploring Sexuality – Breaking the Silence, Vol 3 No 1, April 1999

Other Resources

Comprehensive reading lists on the issue of Sexuality may be found in the following books:

1. Appendix 1 of " Learning about Sexuality - a practical beginning, Sondra Zeidesnstein and Kirsten Moore; 1996; New York; The Population Council and IWHC
2. A Source Book - Insearch of Feminist Visions , Alternative Paradigms and Practices; Compiled by Lasshmi Menon; 1995; Mumbai; Indian Association of Women's Studies and AKSHARA

Videos - Videos on the theme of sexuality include

Subah ka bhoola; NGO-AIDS Cell, AIIMS, New Delhi

Safer-sex; NAZ , New Delhi

My Children should be running through the vast open spaces- MADHYAM, Bangalore

Guhya - Kirtana Kumar , Bangalore

Newsletters

There are a number of newsletters for gay and lesbian and transgendered people. Some of these are-

Network; New Delhi

Bombay Dost; Bombay Newsletter for gay, lesbian and transgendered people.

Arambh ; Gay and Lesbian Newsletter.

Trikone; San Francisco; For south Asian gays, lesbians, bisexuals and transgendered people.

Pravartak; Calcutta; gay newsletter

Friends India; Lucknow; gay newsletter.

ILIS Information, Belgium, Lesbian Newsletter.

Support Groups for gay and lesbians include:

Drishtikon

ABVA, New Delhi

Humsafar Trust; Bombay

Arambh Support Group for gay men and women; P.O.Box 9522, Delhi - 95

Campaign for Lesbian rights; New Delhi

Sabrang; Bangalore

Good As You; Bangalore

Humrahi , support group for gay men, New Delhi

Sangini, support group for lesbians and bisexual women, New Delhi
Durbar Mahila Samanwaya Committee c/o SHIP, Calcutta

Resource Organisations

CEHAT (Centre for Enquiry into Health and Allied Themes) - The Ford Foundation has/had supported a large number of studies on reproductive health and especailly sexuality. The reports of these studies and other studies can be obtained from CEHAT.
CEHAT,
2nd Floor BMC Maternity Home,
135 Military Road,
Bamandaya Pada, Marol,
Mumbai -400059

IFSHA - IFSHA is working exclusively on sexuality and provides support in the form of Information material, Training programmes, Counseling services and so on. The contact information for IFSHA has been given earlier.

The Ford Foundation - The Ford Foundation is an American private foundation which has supported a number of studies and interventions in the area of sexuality and sexual behaviour. For furtehr information pl;ease contact:
Programme Officer (Reproductive Health)
Ford Foundation,
55 Lodhi Estate,
New Delhi 110003

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**UNDERSTANDING
REPRODUCTIVE HEALTH**

A Resource Pack

Booklet- Twelve

WOMEN HAVE MINDS TOO!

Exploring The Interface Of Reproductive And Mental Health

SAHAYOG

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INTRODUCTION

The relationship between reproductive and mental health is a topic which, at best, inspires cautious scepticism, and at worst, downright dismissal from public health practitioners in developing countries. Mental health has always been the Cinderella of health concerns in developing countries, even though health policy and social components nearly 30 years ago. More recently attempts to place mental health on the public health agenda are confronted with the serious concerns of old and new infectious scourges ravaging the low-income world, and the threat of non-communicable disorders such as heart disease and diabetes becoming a reality where does mental health fit in? Can we really afford to be mentally well when our bodies are sick and our stomachs empty? Is it a luxury item on the health menu derived from Western preoccupations now that they do not have to fret about resources to mental illness with its vague fuzzy boundaries and connotations of asylums shock therapy and madness? Besides, do women who are facing so many pressing problems in their lives really have time to become mentally ill? Isn't mental illness largely due to consumerism and materialism? These are just some of the cliches and challenges one faces in a discourse on mental health.

Reproductive health and Mental Health

How does mental illness relate to reproductive health? As this booklet will demonstrate there are numerous close linkages between these apparently different health domains. This arises from the fact that just like reproductive health, women's mental health can not be considered in isolation from social, political and economic issue. When women's position in society is examined, it is clear that there are sufficient causes in current social arrangements to account for an excess of common mental health problems experienced by women. Gender dynamics and power relations which lead to an unequal status for women in a variety of situations are likely to make their lives more stressful. Indeed, "it is not surprising that the health of so many women is compromised from time to time. Rather, what is more surprising is that stress related health problems do not affect more women" (see Dennerstein et al, 1993; Reading Material). The area of intersection of reproductive and mental health though rarely researched so far provides an opportunity to explore women's mental health from a perspective which is now widely accepted as a fundamental health priority for women. This section of the Reproductive Health Resource Pack briefly tries to understand Mental Health, its linkages with reproductive health, current issues and debates pertaining to programs and policy relevant to women's issues and recommendations for future research.

Section One

Understanding Mental Health And Mental Illness

What are mental health and mental illness

In Indian languages the word 'manasik' is usually translated into English as 'mental'. It originates from the word 'man' which includes both emotional and intellectual capacities. However, the English word 'mental' attends to the latter and may neglect or occlude the emotional aspect. This is not just a linguistic issue because the word 'mental' is associated with much stigma in India due to its association with colonial institutions such as mental asylums and inhumane treatments. Perhaps the first issue that needs clear understanding is that mental illnesses, like physical disorders, constitute a wide range of specific conditions and that many of these are closely associated with community health issues. Thus, the very diverse conditions of infantile autism and hyperactivity, depression and schizophrenia, alcohol and drug abuse, Alzheimer's disease and mental retardation all fall under the broad umbrella of mental health. Even though mental illnesses are such a varied group of health problems disorders, such as **schizophrenia**. It is this group of disorders which are the predominant conditions in psychiatric hospitals and clinics in developing countries. However in a community setting, they are rare. When women suffer these disorders, they are likely to suffer far greater discrimination and stigma in areas of life such as marriage and employment than men.

Depression and anxiety disorders, on the other hand, are rarely seen in psychiatric clinics. They are collectively referred to as "**Common Mental Disorders**"(CMD). The term CMD is used as an alternative for depression, both terms are used to refer to those health problems characterised by a mixture of medically unexplained physical symptoms such as tiredness weakness and aches and pains, behavioral symptoms such as sleep and appetite disturbances and psychological symptoms. Studies from South Asia reveal that up to 40% of adult primary care attenders suffer from a Common Mental Disorder Both Community based studies and studies of treatment seekers indicate that women are disproportionately affected by common mental disorders. A recent collation of 5 studies from 4 low and middle income countries demonstrated the women were 2 to 3 times more likely to suffer CMD than men (see Patel et al, 1999: Reading Material). Depression has been shown to be a chronic illness with upto 40% of patients in treatment settings remaining ill for 12 months or more. Patients suffer a higher mortality both as a result of suicide and other causes. Patients frequently consult health clinics, but due to stigma and other factors, prefer to consult general physicians with somatic (or physical) complaints rather than psychological complaints. Indeed, this is one of the key problems in using terms such encounter patients who state their complaint as being feeling "depressed". However, even the simplest questions about mood and thoughts often reveal the classic, "hallmark" features of depression. These include: loss of interest in daily life and social activities, sadness, worry and suicidal feelings. There are effective, and relatively cheap, treatments for CMD: yet, the vast majority of patients in India do not have access to these and are,

instead, given sleeping pills and other symptomatic medications and subjected to numerous investigations and tests. Other mental illnesses which the community health workers may encounter are habit problems such as alcohol abuse and drug abuse. At present, evidence suggests that these problems are relatively uncommon in women in India. Mental retardation is a condition which is present from birth or early infancy and is associated with delayed development of the child's intellectual abilities.

Thus, mental illness is a common and disabling cause of ill-health in developing countries. The recent Global Burden of Disease (World Bank/WHO., 1996) report listed the most important causes of disability (as measured by disability Adjusted Life Years, a measure of the number of years of life lost by disability due to a specific illness). To the surprise of many public health experts, five of the top 10 causes of disability were mental disorders: depression, alcohol abuse, schizophrenia, bipolar disorder (also referred to as manic-depressive disorder), and obsessive compulsive disorder. Depression was the single most disabling disorder, accounting for more than one in ten years of life lived with disability.

Linkages between Reproductive Health and Mental Health

One can identify several areas where mental and reproductive health areas intersect, most notably the following:

- **Reproductive Symptoms and Psychological Disorder :** Weakness and tiredness are some of the most common symptoms reported by women in community and primary care populations. Weakness is almost always taken to be caused by anaemia. However, weakness is also a hallmark symptom of depression. A number of recent studies have demonstrated that many women with complaints such as weakness and white vaginal discharge do not have reproductive tract infections which can account for these symptoms. Thus, it is possible that these women are using the reproductive somatic idiom to seek help from medical professionals and to escape albeit temporarily, from a stressful situation. In extreme situations, women may adopt the sick as refused of sex and inability to perform household chores. However, by adopting this idiom, they are subjected to a series of medical examinations, investigations and treatments which rarely tackle the key psychosocial issues which underpin their distress.
- **Childbirth and Mental Health :** Women are vulnerable to suffer depression during the period immediately following childbirth. Most research on Post-Natal Depression (PND) is from industrialised countries, this research demonstrates that PND can be detected in about 10-20% of mothers. The majority of PMDs are self-limiting though, if untreated, this process of resolution may take upto 6 to 12 months. There is a compelling body of evidence implicating PND in a range of adverse child cognitive and emotional outcomes. The detection of PND is of great public health interest not only because of its profound impact on maternal and child health but also due to the abundant evidence that simple inexpensive interventions such as counselling are of significant benefit in terms of remission of PND and help prevent some of the adverse outcomes associated with PND. The emphasis in postnatal planning ignoring the

mother's psychological health: this child-oriented approach renders the mother less likely to discuss her own distress since it may be viewed negatively by her family and health workers.

- **Family Violence and mental health:** Violence against women is emerging as a pervasive global issue and contributes significantly to preventable morbidity and mortality for women across diverse cultures. There is now substantive evidence demonstrating that amongst the most disabling and long-lasting health effects of violence are mental health effects such as depression and Post Traumatic stress Disorder(PTSD); other recognised mental disorders associated with violence are eating disorders, sexual dysfunction and suicidal behavior. The harmful impact of sexual violence and abuse in childhood has been shown to lead to mental illness in adult life. There is evidence that women who have been abused have difficulties in forming trusting, stable relationships and may end up in more abusive relationships in the future. Friends and relatives can be very helpful if they suspect an abusive situation. Support groups and counselling both can help a person in an abusive relationship. People in same-sex partnerships also face abusive relationships and may need such help.
- **Rape and mental health :** Rape is one of the most terrifying experiences that any human being can experience. It is not only a violation of a woman's body, but of the most sensitive aspect of her being, her sexuality. In many communities, the woman suffers the double blow of suffering rape and then being accused or discriminated against by other members of her community. In this sense that rape involves both physical violence and mental torture, it can be extremely damaging to a woman's health. Typically, a woman goes through a series of emotional reactions. The woman may be tearful, shaking with fear and anger and unable to understand what she has just experienced. Some women may appear calm and controlled, this does not mean that they have coped well with the rape. In the days and weeks after a rape, a variety of emotions re experienced Blaming oneself, fears of being killed or harmed, feeling of humiliation, feeling dirty, repeated thoughts of the rape, nightmares and sleep problems are common. Physical complaints such as aches and pains, loss of appetite and tiredness are also common. Later on the woman may develop a fear of people behind her, fear of situations similar to those in which the rape occurred, fears of loss of interest in Disorder. As a woman recovers her self-esteem, often sadness and tear remain for a long time. In the end the majority of woman do recover from the trauma but not without having suffered severe ill-effects for a long time in a few women, though, frank depression can occur and will need treatment.
- **Child Abuse & Mental Health :** Both male and female children can victims of child abuse. Abuse can be emotional (such as neglect), physical (such as beatings), or sexual. Children who are abused usually appear the same as those who are not abused. However on closer examination they may appear tense and unhappy, present with a deterioration in school performance, and may complain of a number of physical symptoms such as stomach aches, headaches, sleeplessness, and eating problems. In

adolescents, antisocial behavior and drug abuse may be signs of abuse. Some may become troublesome at school or steal. Many children blame themselves for the abuse that they see in their households. Children in abusive households may have more trouble dealing with their anger because they may learn that anger means being hit or being violent towards others.

- **Reproductive tract Surgery and mental health :** Women who undergo reproductive tract surgery such as tubectomy, mastectomy and hysterectomy may face mental health related problems. Gynecological surgery poses a unique stress for women because of the identification of the reproductive organs both with sexuality and with the wider concept of feminine identity. This stress is particularly apparent when one considers mastectomy or hysterectomy. Of all cancers, breast cancer is arguably the most frightening for women. Mastectomy involves emotional trauma of losing a breast, in addition to numbness of the skin, scarring, and posture problems. Nothing can restore the sexual and nursing function of the lost breast, even if reconstruction of the breast for appearance is possible. Counselling may help ensure optimal sexual outcome for women undergoing such surgery. Although Cesarean delivery is now safer than it has ever been, it remains a major surgical procedure and therefore can never be an entirely safe alternative to vaginal delivery. A number of negative responses to a caesarian delivery among women have been reported. These responses include fear, disappointment, anger and lowered self-esteem. In addition to the stressors that women have to cope with may have occurred on top of a long and exhaustive labour.
- **Abortion and pregnancy loss :** Although grief has been understood and documented for many decades, only recently have the full impact and consequences of pregnancy loss been appreciated. Unique aspects of pregnancy losses surrounding miscarriage and ectopic pregnancy, stillbirth or neonatal death include: real (actual) loss of a person; and symbolic loss (of the future) in addition there is a loss of self-esteem resulting from the woman's inability to rely on her body and give birth. Emotional shock, feelings of loss, sadness, emptiness, anger, inadequacy, blame and jealousy are common feelings experienced after post-natal loss. Each pregnancy loss may mean that there is no recognisable body to visualise, and this further complicated the mourning process. Symptoms suffered by women in case of stillbirth and neonatal death include depression, sleep disturbance, social withdrawal, anger, guilt and marital disturbance.
- **Adolescent Sexuality & Mental Health :** The sexual health of adolescents is rapidly becoming the newest "buzz" word in reproductive health research. However, there is a risk that the agendas and priorities of reproductive health workers may miss out on the other real concerns of adolescents and their families, viz., stress arising from conflict within families and from pressures in the educational system and rising unemployment. There is now substantial evidence pointing to the rising rates of depression and suicide amongst young people. Suicide has become one of the commonest causes of death and hospitalization in adolescents in many societies. Pressures of academic performance can lead to considerable psychological stress and symptoms of

weakness, lack of concentrations, headaches and so on. Peer pressure is an important factor that influences the mental health of adolescents. Peer pressure can force an adolescent to experiment with sexual behavior in order to be accepted in the peer group. Peer pressure can also force an adolescents dealing with their homosexuality can be especially vulnerable to mental health problems as they have to cope with their sexuality and other related issues with little support or approval. Anxiety around pubertal changes may also cause mild to severe mental health problems in the adolescents. They often worry about matters such as menstruation, masturbation, delay in the onset of puberty, size of breast, penis and so on. Young men sometimes believe that semen is a source of physical strength and vitality. They become very concerned when they notice that they are "losing" semen by passing it in their underwear during the night, or when passing urine or stool. They may become very anxious about their desire to masturbate and, if they do masturbate, suffer guilt and tension because of this. Many men will go on to complain of tiredness, aches and pains, impotence and suicidal feelings. Typically, they will blame these complaints on the passing of semen(Also called "dhat" in North India) in their urine. The health worker must spend time explaining male sexuality. An example which helps is that of a glass of milk to which more milk sexuality. An example which helps is that of a glass of milk will begin to dribble out of the glass; this is the same that happens with semen.

- **PMS, Menopause, and Mental Health :** The combination of emotional, behavioral, cognitive and physical changes occurring pre-menstrually have been designated as a syndrome- the premenstrual tension syndrome(PMS). Typical symptoms of PMS include irritability, mood swings, poor concentration depression and tiredness. The symptoms complained of by women in the menopause - headaches, weepiness and depression , irritability , anxiety, insomnia , fatigue, lack of sexual feeling- are conditions which are just as real and which can be even more worrying than the other major symptoms attributed to menopause such as hot flushes , vaginal dryness and osteoporosis (porous and fragile bones). Hormonal replacement therapy helps reduce the physical problems but does not do much to help relieve mental health problems associated with Menopause. It is worth noting that older women, past the menopause, are often at high risk of depression due to a number of reasons such as loneliness.
- **HIV/AIDS and Women's Mental Health :** HIV/AIDS produces mental health problems in those who suffer from the disorder for a variety of reasons including the stigma and discrimination associated with the disorder, the obvious implications of diagnosis to long-term survival, the impact of discovering an illness which may have already infected loved ones in the family, and the direct and indirect effects of the HIV and secondary neoplastic and infectious diseases on the brain. The effect of caring for terminally ill persons on the mental health of carers is now recognized as an important cause of depression. There are growing reports that women, who are often carers for persons with HIV/AIDS, suffer considerable mental and physical health problems as a result of care giving and that depression, in particular, is common.

Section Two

Programs & Policy: Issues and debates on Women & Mental Health

The rights of the mental ill, and the improvement of mental health care

On December 1991, a set of principles for the protection of persons with Mental illness and for the improvement of Mental Health Care was approved by the United Nations General Assembly. The principles provide comprehensive protection for a particularly vulnerable group that is readily susceptible to discrimination. Persons in this group are vulnerable because of their disturbed mental state, which prevents them from making reasonable judgments about their own needs. As a result, mentally ill persons are often given least priority in terms of access to care and services. It is true that mentally ill people can sometimes be dangerous to themselves or to others, although this hazard is often greatly exaggerated. The principles attempt to set forth safeguards against such hazards without ignoring the fact that such provisions are particularly liable to be abused by family members, other members of the community or state authorities. If a national jurisdiction follows this balanced set of principles in drafting domestic law and in instituting procedural modalities, both the rights of the mentally ill and improvement in mental health care can be accomplished. However, as with many other grand and well-meaning legislations in our country, there is a vast gap between ideology and practice. As recently as 1999, a National Human Rights Commission inquiry on the condition of mental hospitals reported horrifying abuses of mentally ill women in some large asylums. These included the inappropriate use of ECT (shock therapy), Sexual abuse of patients and gross neglect of medical care. It is important to keep vigilant of whether the recommendations of the commission are implemented in the years ahead. Some other important legislative changes in recent years include the revision of the Disability Act to include mental disorders, and the rewriting of the old Indian Mental Health Act to be more Sensitive to the needs of mentally ill people.

Hysterectomy of mentally retarded women

When the media reported that a State run institution in India has conducted hysterectomy on eleven mentally retarded women, it sparked off an explosive public debate. Issue such as human rights, medical ethics, the right to survival and reproduction, dignity and decency, responsibility of the family and the State were all placed under the spotlight. The primary argument of the proponents was that it was essential to conduct hysterectomy to maintain menstrual hygiene of the mentally retarded women. Avoiding unwanted pregnancies and sexual abuse have been used only as secondary arguments. The key question for human rights and health activists is whether this is the best that science today can offer to this normal aspect of human functioning. Since hysterectomy is an irreversible process, should we resort to it as a matter of routine and worse as a matter of policy. If we accept this practice for the mentally retarded women, then will other vulnerable and or 'unwanted women' like women who beg, HIV positive women and orphan girls be the next

group to be considered eligible for such involuntary operations? Should not an enlightened society develop a code of medical ethics and procedures for safeguarding the wards from possible abuse? These are issues and debates which must involve both mental health professionals and women's activists in collaboration health policy claims to codify a radical shift from the medicalised mental health practices, such as mental hospitals to the social model of community care. However, in practice, it makes minimal changes in the overall perception and management of mental disorders. Indeed, the NMHP remains largely unknown outside psychiatric hospitals, defeating its very purpose. The NMHP needs to be rectified so that its goals and methods are altered from a medical model to a psycho-social model, from a psychiatric oriented model to a community health oriented model, and from making a purely clinical commitment or making a social commitment. It is worth noting that this discrimination towards women's mental health afflicts many women's health researchers and donor agencies too! Thus in India women's mental health is addressed by only a fraction of reproductive health programs and policy. Many women's activists dismiss mental health as a relevant issue in their work. Some even argue that the mental health discourse is in itself an attempt to divert attention from gender discrimination. This sort of argument is as senseless as saying that treating a woman's fractured body is a distraction from the "real" problem, i.e. the gender power dynamics which led to her being severely beaten by her husband. Clearly, both the supposed cause and the resulting health problem need action. As this article has shown, there is a need for a far greater degree of acknowledgment of the importance of mental health to a woman's overall well-being.

Media and mental health

Media plays an important role in perpetuation of gender determined roles and stereotypes which are potentially damaging to women's psychological well-being. The impact of media on women and their mental health are manifold. Media contributes significantly to the dilemmas and conflicts that women face in many aspects of their lives as a result of the promotion of rigid, limiting and unreal sex roles and stereotypes. The portrayal of the "insane" woman or the wicked mother in law in Hindi movies often subscribes to negative stereotypes of a woman's emotional nature. These cannot be ignored. There is, in contrast, very little sensitive portrayal of the experience and needs of mental illness in women. Media coverage must shift from being minimal, sporadic and informing the community. Forging links between mental health professionals and media persons interested in mental health issues can go a long way to help generate better coverage and discourage negative role stereotypes.

Mental Health Services and Care

In India, the involvement of the family in the care of its mentally ill member has always existed, in keeping with the philosophy of 'karma'. Due to inadequate mental health facilities, most patients have lived with their families who have provided the attention and care in times of need. However, for some women, family attitudes may make their care doubtful or even harmful. Furthermore, there is also the need for professional care for

many types of mental illnesses. In addition, just because families caring for the mentally ill also need guidance and support. Thus, there is a need for systematic organisation of essential services for mentally ill women especially those living in rural, tribal and urban slum areas. Requirements of working women and girls on the street represent another group who require innovative approaches to meet their mental health needs. There is a need for innovative, cost effective services which are in harmony with existing socio-political and cultural norms. This is more likely to be achieved by thinking in terms of local initiatives, appreciating the power of micro-planning at the villages/grass root level, rather than orienting towards centralised plans, programs and projects. During the last two decades, a number of innovative approaches have been developed to meet the deferent needs of people with illnesses, to prevent mental disorders and to promote mental health. Some of these innovations are described in detail in a forthcoming book (Patel & Thara, Reading List). The overall picture is one of tremendous scope, positive initial experience and the need to enlarge and over larger groups of population all parts of the country. The key to sensitive mental health care delivery for women lies in two major programme areas; first, the inclusion of mental health as a priority in existing community and women's health programmes and second, the sensitisation of health workers to the unique mental health needs of women and the need for a revision of the NMHP to accommodate these needs.

Section Three

Women and Mental Health Research: An agenda for the future

Future research must explore and determine the linkages between mental and reproductive health. A key area for any research investigation in mental health is examining its relationship with cultural factors. Concepts such as depression, can be elicited in different cultures, but may mean something quite different; for example, it may reflect the patients assessment of their socio-economic and spiritual state. As a result, persons with depression rarely consult mental health professionals and tend to use somatic idioms such as vague aches and pains. Therefore, it is essential to generate a local language of depressions and to explore its contextual significance and the explanatory models of the depressed individual; what the person believes is causing her distress, her understanding of the changes that are affecting her and how the distress has affected her daily life. Epidemiological research in itself has severe limitations in accurately describing women's mental distress, such as posttraumatic stress disorder or major depression that are linked to socio-political and economic realities. Feminist perspectives on women's health underscore the importance of "treating survey methods for their gender bias" and using more innovative instruments to collect accurate quantitative data on women's mental distress. In this respect, ethnographic research may also be valuable in exploring reasons why women are more vulnerable to suffer from Common Mental Disorders and the mechanisms by which these disorders lead to disability. Several themes and hypotheses for research are considered below.

- How common is postnatal depression? Which women are more vulnerable to suffer PND? What is the impact of postnatal depression on infant and maternal health? What is the role of fathers in this context?
- What are the fears and desires that women have regarding their own bodies and sexual lives? How do researchers and programmers incorporate emotional aspects of sexuality into the reproductive health parading?
- What the health priorities and concerns for adolescents? What is the relationship between gender, dropping out of education, stress related to education and mental health? How do these factors interact with sexual and reproductive health in adolescents?
- What is the relationship between the common complaints of white vaginal discharge and weakness with mental health? Are these idioms for psychosocial distress? If so, do women benefit from receiving mental health interventions for these symptoms?
- What are the mental health consequences of domestic violence? Can family or marital therapy interventions help in these situations?
- What is the relationship between infertility and mental health? Can counselling interventions help couples with infertility problems?
- What is the mental health impact of AIDS for women, both when they are themselves suffering from the disorder as well as the impact of being carers of relatives with the disorder?

- What is the impact that community based interventions for either reproductive or mental health issues have on both health outcomes/
- What is the impact of reproductive tract surgery and abortions on women's mental health? Can counselling help reduce this impact?

Society, women and mental health

Studies in the area of physical health show how the organisation of health care in the country has been designed to privilege a certain class at the expense of others depending upon the socio-economic status and the function of individual in a society. It is well-documented that women in particular, have been the enduring victims of this political organisation of health care. Statistics on the prevalence of mental illness in the community show that women are more frequently ill than men. In general, the utility of mental health services is not commensurate with the prevalence between prevalence and utility (see Bhargavi Davar, 1999, Reading List). In India the proportion of women attending the facilities is very low, as compared to men. This low attendance is partly explained by the non-availability of resources for women. The traditional mental health services appear to primarily cater to the needs of male patients. Research indicates that mental hospitals show gender -discrimination in terms of availability of beds. In short, even though women are more frequently ill in the community, their utilisation of mental health services is lower than men. This discrimination is also visible in the access to mental health care of mentally handicapped children. Besides this, parents of handicapped young girls are less motivated to send them to these institutions for rehabilitation. There are no economic gains in doing this, as there might be in the case of boys who can still be trained for some useful employment. The mentally handicapped girl also helps out with the household chores. As she is unlikely to get married, parents would think it a waste to expend resources, material or psychological, on her.

Mentally ill people, in general, are forced to suffer a stigma in addition to their psychological suffering. Social attitudes towards and understanding of mental illnesses in women are much more pernicious than that towards men. A mentally ill man is an economic burden, but a mentally ill woman is an economic as well as a moral burden. Mentally ill women may be severely condemned for any behavior that could be perceived as a violation of feminine nature and modesty, such as tearing off clothes, violence towards others, lack of attention towards the preparation or consumption of food, neglect of children, etc. Mental illness in women is seen as a moral disgrace to the family and thus censure, neglect, rejection and isolation are commonly associated with mental health. In the case of men it is a cause for sorrow, not disgrace. Many mentally ill women receive no social support, either from their family or into the family into which they get married. Married and mentally ill women are more likely to be sent back to their natal homes, abandoned, deserted or divorced. Our social way of life, its hierarchies, gender relations and social structure, other than our perception of mental illness, all contribute towards the large scale neglect of mental illness in women. A concerted advocacy campaign could be one major way of changing such negative and regressive attitudes.

Mental Health Policy and women

Our current National Mental Health Programme also reflects this culturally pervasive insensitivity towards the mental health needs of women. This policy prioritises the severe mental disorders like epilepsy and psychosis, whereas it is the common mental disorders that are frequently found among the women in particular and the community in general. Our national policy reflects the priorities of the WHO, which is informed by cost-effectiveness of implementation of policy rather than community need. While severe mental disorders are more easily managed through the mental health and primary health care infrastructure already available, common mental disorders require insight into the social reality of the patient. Pharmacological interventions cannot be used in isolation, and often, counselling and family therapy, may be required. All this needs long term social planning and considerable shift in the current training and curricula for health workers of all grades. Our current women's health needs should not be compartmentalized into "reproduction", "mental", "physical" and so on. The key to a realistic understanding of health needs is accepting that such categories are artificial. Indeed, it can be argued that categories are created more to satisfy the needs of researchers and activists whose experiences and training have been compartmentalized, than to cater to the real needs of ordinary people. Thus, reproductive health research and programming will need to incorporate mental health and mental health research and programming will need to incorporate reproductive health. The many potential themes of intersection of these two crucial health domains described earlier provides an avenue for exploring these issues using already existing networks and resources and without risking the stigmatization of women who would, otherwise, not wish to be associated with a "mental illness". While it may be premature to suggest interventions that address mental issues, reproductive health researchers should take the initiative to provide sufficient evidence to policy makers and health programmers that Women Have minds too.

country was too high was started in the 1930's . It was also concurrently argued that India was the wealthiest country in the world with the poorest people, and the Nationalist minded held that Independence would tilt the balance. At the same time many organisations were founded on Malthusian lines and started working for family planning and population control. Subhas Chandra Bose and Jawaharlal Nehru were also strong advocates of family planning. The objective of most of these efforts were to ensure greater socio-economic development. It must be noted that the initial impetus to population control came entirely from Indian concerns for development. Later on the programme and polices became influenced by foreign experts and donor organisations which helped by introducing an extension based approach but also introduced the much maligned target based monitoring system.

Much has been written about India's Family Planning Programme - justifying its successes as well as some of its major shortcomings, and the interested reader may refer to some the excellent papers on the subject. But one thing that was becoming increasingly clear that Family Planning and its targets was becoming an obsession with the administration- right from Districts Magistrates/Collectors to lowly village level functionaries. Under the pressure to obtain the right targets all forms of practices from persuasion to pressure to blackmail was being used to get women under the surgeons scalpel, while surgeon in many cases threw basic aseptic and surgical norms to the wind to increase their tallies and records. In this hurry many women well past menopause were sterilised, others underwent multiple sterilisations and unfold millions underwent other major and minor complications. And almost all these were women. In the madness of chasing family planning targets women's health took a back seat. Despite some achievements in lowering birth rates India's Family Planning programme had begun to draw flak from within and outside the country, particularly from women's health activists who demanded greater attention to women's health needs and a shift away from the method specific target fever which used to grip the nation between January and March. The ICPD was a much needed boost to the concerned citizens of the country because with it came many much needed changes in the programme. These will be discussed in the section on Reproductive Health- Policy and Advocacy .

No discussion on Population Programmes in India can be complete without a mention of Kerala. Kerala's performance in the population control front is seen as an oasis in the other wise barren landscape in India. The various studies and articles on Kerala's remarkable demographic parameters have very clearly brought out the fact that these were not due in any way to the National Family Planning Programme but to the socio-economic-political conditions prevailing in the state. In fact comparing Kerala with the program in China clearly outlines some of the shortcomings of a state sponsored family planning programme for controlling birth rates and family sizes. Notably the position of women in Kerala is far superior to that in China.

Section Three

Working On Population Related Areas

As has been mentioned earlier Population and Demography is essentially a multidisciplinary subject and there are a large number of disciplines involved . In India the study of population has been particularly significant because of our large population and in order to devise ways and means to control the growth in numbers as well as finding development solutions. There are many policy research and think tank group engaged in working on the myriad of issues . Names and addresses of different organisations working on the issue concerning population and demography from different perspectives is given below. This list does not purport to be a complete list in any way.

Organisations working on Population related areas

Centre for Development Studies , Thiruvananthapuram	Prashanthanagar, Ulloor, Thiruvananthapuram, Kerala-695011
Centre for Operations Research Training (CORT)	405, Woodland Apartment, Race Course Road, Vadodra – 390007, Gujarat Ph-0265-326453/326034/336875
Centre for Social and Technical Change (SOCTEC)	14, Bandstand Apartments, B.J. Road, Bandra (W), Mumbai-400050 Email- soctec@viasbm01.vsnl.net.in
Foundation for Research in Health Systems	6, Gurukripa, Apartments, 183, Azad Society, Ahmedabad, 380015 Email- frhsad@ad01.vsnl.net.in
Gujrat Institute of Development Research	Gota Char rasata, Gota, Ahmedabad-380481, Ph-079-474809
HEALTHWATCH	C/o Vimala Ramachandran 10 B Vivekananda Marg, Jaipur, 302001, Ph-0141-360158
IIHMR	1, Prabhu Dayal Marg, Sanganer Airport, Jaipur-302011, Rajasthan Email- root@iihmr.sirdnetd.ernet.in
IIM,Ahmedabad	Public Systems Group, IIM Vastrapur,

National Addiction Research Centre. 1994. Hysterectomy and the Mentally Retarded Women: Issues and Debate. Bombay: National Addiction Research Centre.
 NIMHANS. 1990. Training of PHC Personnel in Mental Health Care. Bangalore: NIMHANS.
 Sriram, T.G. et.al. 1990. Manual of Psychotherapy for Medical Officers. Bangalore: NIMHANS.
 VHAI. 1995. National Level Workshop on Alternatives in Women and mental Health. New Delhi: VHAI.

Resource Organisations working on mental health (in alphabetical order)

The following organisations are a selections of groups who have been working in the area of mental health and women/reproductive health.

Anveshi:

This NGO is based in Hyderabad and has been active in the field of women's mental health policy and theoretical research. One of its founders, Bhargavi Davar, has written a book on the mental health of women in India. It is currently proposing to develop materials for community based interventions for common mental health problems in women.

For more information for common mental health problems in women. For more information, contact Bhargavi at: davar@pn2.vsnl.net.in or write to: Rekha Pappu, Anveshi Research Centre for Women's Studies, OUB-1 Osmania University Campus, Hyderabad, 500007.

IFSHA:

Interventions for Support Healing & Awareness is an NGO, based in New Delhi, which works in the area of the mental health impact of violence and sexual abuse. It has recently published a report on research it conducted on the experience of violence in women who were admitted to psychiatric hospitals. It runs a counselling centre in New Delhi.

For more information contact Jasjit Purewal or Maya Ganesh <mailto:seher@del3.vsnl.net.in> or by mail to: J39, 1st floor, South Extension 1. New Delhi 1100049.

NIMHANS:

The National Institute of Mental Health & Neurosciences is an autonomous University in Bangalore which is the leading academic institution working in varied fields allied to psychiatry, psychology and neurology. It is essentially a training institution for doctors and mental health professionals but does host a variety of programs and workshops. Many of its staff work closely with NGOs and in community mental health programs. Persons you can contact who have an interest in reproductive health are Dr Pratima

Murthy, Dr Prabha Chandra, Dr Santosh Chaturvedi and Prof Mohan Lsaac in the Department of Psychiatry, NIMHANS, Post Bag 2900, Bangalore 560029.

Sangath Society :

This NGO is based in Goa and its main activities are focused on behavioural, developmental and emotional problems facing children and families. The author of this article is a founder-member of Sangath. Sangath's main activities are in the fields of Child Development & Learning Disability Adolescent Sexuality, Family violence, Depression and other mental health problems affecting families. Ongoing research projects include studies on postnatal depression, the use of counselling for the treatment of common mental disorders, the impact of violence on the mental health of women and children and adolescent mental health. The Society has a multidisciplinary approach to behavioural problems and its staff include doctors, social workers, psychologists and teachers. For more information, contact Vikram mailto:vpatel@vsnl.com (address:Sangath Centre, Porvorim, Goa 403521).

SCARF:

The Schizophrenia Research Foundation in Chennai is India's leading NGO working exclusively in the field of mental health. It is a recognized WHO Collaborating Centre and has pioneered a comprehensive range of services for persons with severe mental disorders. It has an active research program dealing mainly with schizophrenia and has published many articles on its effect on women. The Director, Dr R Thara can be emailed on : scarf@md2.vsnl.net.in or by mail to Schizophrenia Research Foundation (SCARF), R/7 A, North Main Road, West Anna Nagar Extn, Chennai 600 101

TISS : The Tata Institute of Social Sciences (Mumbai) is a leading autonomous institution in the field of the social sciences in India. It has a department of Medical and Psychiatric Social work which has been conducting programs and research in various aspects of mental health. Key contact persons are: Dr Surinder Jaswal, Dr Purnima Mane or Kety Gandevia, at TISS, Sion-Trombay Road, Deonar, Mumbai 400088. Dr Jaswal can be reached on : surija@tiss.edu

Other Resources

You may also find resources in local medical schools or psychiatric hospitals in many parts of India. Some other contact addresses and resources in the non-governmental sector are:

1. **Alzheimer Diseases & Related Disorders Society of India (ADRDSI):** Dr Jacob Roy, Villa Tropicana, XV/496 Thrissur Road, Kunnankulam, Kerala 680502 : Works in the field of family support and care for patients with Alzheimer's Disease.
2. **Antarnad :** Dr Apoorva Shah, 402 Shikhar, nr. Mithakali Six Roads, Navrangpura, Ahmedabad : Works in the field of psychotherapy and child mental health

3. **Forum for Mental Health Movement:** Ms Ratnaboli Ray, 93/2 Kankulia Road, Benuban#A302, Calcutta 700029: A collective of NGOs working in mental health and allied fields
4. **Medico-Pastoral Association :** Lata Jacob, 47 Pottery Road, Fraser Town, Bangalore : 560005: Provides residential care and rehabilitation for severe mental illness
5. **Paripurnata :** Dr J Siromoni/Dr S Mukherjee, 5B Swarnamoyee Road, Calcutta 700009. Works for severe mental illness.
6. **Richmond Fellowship Society;** S Kalyanasundaram, Asha, 501, 47th cross, 9th Main, Jayanagar, V Block, Bangalore 560041. Provides residential care and rehabilitation for severe mental illness
7. **Samadhan:** Pramila Balasundaram, Day Care Centre, Block F, Main Park, Sector V, Dakshinpuri, New Delhi 62: Works in the field of mental retardation
8. **Sneha:** Dr Lakshmi Vijakumar, 4 Lloyds Lane, Royapettam, Chennai 14. Works in the field of suicide prevention.
9. **TT Ranganathan Foundation :** Dr Anita Rao, 17 IV Main Road, Indira Nagar, Chennai 600020. Works in the field of alcohol abuse.

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